CHAPTER 2

CLAIMS MANAGEMENT INFORMATION FOR MCOS

B. COMMUNICATING WITH THE CUSTOMER CARE TEAM (CCT)

1. Customer Care Team

The key to success of the Health Partnership Program (HPP) is creating a strong partnership between BWC's CCT and the MCO. The CCT is lead by a team leader and includes:

- Claims Service Specialists (CSS)
- Medical Service Specialists (MSS)
- Disability Management Coordinator (DMC**)**

The CCT manages the overall direction of the claim, which requires a close working relationship with the MCO. Cooperation between the CCT and the MCO assures quality service to our customers and a potential reduction in claim costs. Each CCT member brings valuable and unique experience to the team. MCOs may be in contact with the various members of the team during the claim life cycle; however, all have the common goal of partnering with the MCO to manage the claim to a successful resolution.

2. Staffing

Staffing is an essential claim management strategy that must occur throughout the life of the claim. Staffing helps to:

- Identify issues, including RTW barriers and injury-related complications.
- Identify and request needed or missing information.
- Decide on the next steps needed to resolve the issues.
- Move the claim closer to resolution.
- Identify additional resources.

Two types of staffing, formal and informal, are recognized and are available for the CCT.

a. Informal Staffing

An **informal staffing** occurs when an issue can be quickly resolved with an impromptu discussion/meeting with the appropriate resource. Brief discussions with the MCO are also considered informal staffing. Informal staffing may be used anytime the CSS recognizes the need, however informal staffing cannot substitute for a formal staffing when required by Policy.

An informal staffing may only be used to resolve issues that do not involve the creation or modification of a CCP. Informal staffing must be

documented in V3 notes.

b. Formal Staffing

Formal Staffing is a multi-disciplinary team approach to claims management. The following disciplines compose the team and are required in the staffing meeting.

- Injury Management Supervisor
- All Claims Service Specialists on the team
- Medical Service Specialist
- Disability Management Coordinator

The following disciplines should be included in staffing as needed.

- MCO
- Lump Sum Settlement CSS
- BWC Policy
- Law
- Employer Service Specialist
- Safety and Hygiene
- Fraud

A formal staffing is scheduled through the multi-disciplinary team meetings. A staffing date can only be entered on the portal claim site, by one of the following team members:

- CSS,
- IMS,
- SOM, or
- Assistant SOM.

A standard format should be followed to provide background data for the issues being staffed, with the Injury Management Supervisor facilitating the staffing process.

c. MCO Participation in Staffing

MCOs should be involved in staffing for:

- Catastrophic claims that are in the acute phase or have ongoing medical issues.
- Claims that have life threatening conditions.
- Claims with triage level 4 (excluding death claims).

Additionally the MCO may be included (but not limited to staffing claims):

- Where the medical therapy is not consistent with allowed conditions.
- When there is a pursuit of MMI or a 90 day exam.
- When a catastrophic claim is no longer in the acute phase.
- When/if the injured worker refuses vocational rehabilitation.

- Where there are provider issues.
- When the injured worker changes POR frequently.
- When the employer has a TWG but is not following it.
- When drug utilization reviews indicate over utilization or receipt of drugs for conditions not allowed.
- When there are frequent disputes for over treatment.
- When TT is being paid due to non-allowed conditions.
- Where there is fraud.
- When there is a lack of medical progression.
- When the injured worker is threatening toward BWC, the MCO or him herself.
- When the injured worker moves out of state.
- If TT is restarted.

Because the **MCO** cannot attend all formal staffing, the CCT's are encouraged to collaborate with the MCO in whatever mode is most efficient and beneficial for them, e-mail, teleconference, onsite, etc. when establishing goals and interventions

3. BWC Policy on Usage of the Portal

Given the new policies related to sensitive information, it is imperative that BWC and the MCOs exchange non-public information in a secure, approved method. The Portal is a secure way to exchange data as it requires passwords for access. The MCO Agreement requires that the MCO terminate the passwords for any employees no longer requiring access or that have left the MCO. MCOs are to maintain a Primary user account on bwc.ohio.gov and create secondary accounts for individuals that need access to the portal. Once the E-user ID is created you need to add this to the Contacts list on your individual MCO site. Adding this to the contacts list will notify the appropriate BWC personnel. When the BWC person adds the E-user ID to the permissions list then the person making the update will be notified via e-mail that the account has been added. Same goes for removing a person. Delete the contact, BWC is notified, and an e-mail will be sent to you letting you know the account has been deleted. It is your responsibility to also go to bwc.ohio.gov and remove the secondary account. With regard to accessing the Bank Statements, CPM libraries, and MCO Bus Secure, please enter a note in the contact list for the person you want to have access (i.e. add to Bank Statements). The process described above will be initiated.

There are three levels to the portal: general access at the MCO Home Page level, secure access specific to each MCO on the MCO Site level, and further limited access to the Bank Statements, CPM libraries, and MCO Bus Secure sites.

MCO Home Page: Contains files pertinent to all MCOs. It contains folders and documents related to new projects (PEACH, NPI, RTW Letters, etc), reference documents (MCO Agreement and Appendices including Policy Reference Guide, EOB list, etc.), and files containing information that used to be on the MCO Update page

(DMC/REA list, MCO ADR Panel list, BWC Cat nurse listing, etc.). None of the information on the MCO Home page is specific to one MCO.

The MCO Update Page folder contains the following:

- Employers in the $15K program
- BWC Cat Nurse roster
- BWC Provider Payment Review
- Voc Rehab Complexity factor form
- DEP doctor list
- DMC/REA roster
- Fields Ops Statewide roster
- MCO ADR Panel
- MCO Update Page slides
- MCO Summary definitions
- MCO Test Kit (EDISM) download instructions
- BWC non-recognized ICD-9s (invalid ICDs)
- Lay-out of Automated Pharmacy Bill History file
- SOC code list
- Future Files:
- List of ICD groupings

The files are updated as needed. Additional files will be added as needed.

The MCO must never delete any files from the MCO Home page.

MCO Sites: Contains contact information for each MCO that is viewable to all MCOs. Users can also generate a list of contacts for all MCOs by the different role types. MCOs must have at least one person designated for each of these roles. The same person can be entered with more than one role (they will have two or more records in the contact list) and/or the MCO can have two or more people with the same role (different billing contacts for different office locations, etc.). There may be staff that does not fall into any of the designed roles. In this case the field should be blank. Valid role types include:

- ADR contact
- Billing contact
- Cat Case Manager (an MCO may have multiple designated Cat Case Managers)
- CAT coordinator
- DUR Coordinator
- EDI MCO contact
- Fraud contact
- MCO Business rep
- Medical Director
- Medical Manager
- Portal contact (person in charge of keeping the MCO contact info current)
- Provider Relations contact
- QCC member
- RIM Coordinator (upon notification by BWC)

Settlement contact
Tech Taskforce contact
Transitional Work contact (upon notification by BWC)
VOC REHAB contact

MCOs are to maintain and keep current the contact information.

The MCO may update the information as often as necessary but must review the site at least once a quarter. This will be the sole source for BWC (main office and the field) and the other MCOs to access contact information for the MCO. The portal allows for a mass update from the contact list by clicking on Actions, then Edit in Datasheet view.

The MCO must also submit an updated Exhibit A when specific staff changes as this is part of the MCO's recertification application and changes must be documented hard copy.

BWC must maintain the MCO details section that contains information related to the MCO's address, directions, phone #, fax #, etc. To do this, go to your MCO's site and click on MCO at-a-glance under Lists on the left of the page.

In addition to the contact information and MCO at-a-glance, the MCO site contains four sections for MCO specific information: MCO specific documents, Bank Statements, Compliance and Performance Monitoring, and MCO Bus Secure.

Bank Statements, Compliance and Performance Monitoring, and MCO Bus Secure are separate libraries, not folders. MCOs must grant people specific access to each of these three sites.

BWC has created the following libraries/folders for each MCO:

- Bank Statements
- Compliance and Performance
- MCO Bus Secure
  - 2013 MCO Agreement (subfolder)
  - Audit Reports (subfolder)
  - Recertification Applications (subfolder)
- MCO Specific Documents
  - ADR
  - CAT PTD assignments
  - HPP Systems Support
  - Inpatient Hospital Bill Accuracy
  - Internal Audit
  - LSS Notices
  - MCO Business Unit
    - DoDM-MoD documents (subfolder)
    - MoD – Detail Files (subfolder)

Open Enrollment (subfolder)
Pharmacy Files (subfolder)
Proof of Compliance with Training Hours (subfolder)
Report Card (subfolder)
Request for Review - Appeals (subfolder)
Weekly Detail Files (subfolder)
Medical Billing and Adjustments
Pharmacy
Provider Relations
Public Information
RTW-OSDD Letters
Transitional Work Program
Voc Rehab

Each folder is related to a department at BWC or a project. The MCO must utilize the appropriate folder when placing files on the portal. The MCO can create subfolders under the main level (such as with DoDM documents under MCO Business Unit) for further clarity.

The following table shows what documents should be placed in each folder by BWC and the MCO and the deadlines, if applicable. This is not an all inclusive list. Both BWC and MCO should include the MCO number and the date of the file in the name of the document.

Once the BWC or the MCO has placed the file on the portal they should send an e-mail to notify the other party that the file is there and confirm the location on the portal.

Library Name	**Folder Name**	**Documents**	**Deadline/ Timing**
Bank Statements		MCO: Provider Account Bank Statements* Reconciliation documentation* 5-Yr Spreadsheet*	 Monthly Monthly Quarterly
Compliance and Performance Monitoring		BWC: Initial CAR reports* Other information as needed MCO: CAR report responses* Information requested by the Department	 As needed As needed By date given By date given
	Retro C-9	MCO: Standard spreadsheet of retrospective C-9's received by the MCO for use in provider compliance*	By 5th day of every month

Library Name	Folder Name	Documents	Deadline/ Timing
	Retrospective Bill Review	MCO: Standard spreadsheet of retrospective hospital bill review results*	 By last day of every month
MCO Bus Secure	Audit Reports	BWC: Correspondence related to review of reports MCO: SAS 70/SSAE 16 report* Audited Financial Statements*	 As needed June 30th June 30th
	Recertification Applications	Recertification Application Updates to Recertification Application (such as updated Exhibit A)	Specified date As needed
MCO Shared Documents:		Documents	Deadline/ Timing
	ADR	BWC: Response to capacity review requests* Other information as needed MCO: ADR capacity review requests* Information requested by the Department	 As needed As needed Within 2 weeks By date given
	HPP Systems Support	BWC: Testing documentation Other information as needed MCO: Testing documentation Information requested by the Department	 As needed By date given As needed By date given
	Inpatient Hospital Bill Accuracy	BWC: Detail of IP Hospital Bill Accuracy errors* Other information as needed MCO: Information requested by the Department	 Monthly As needed By date given

Library Name	Folder Name	Documents	Deadline/ Timing
	Internal Audit	BWC: Initial PARC reports* Other information as needed MCO: PARC report responses* Information requested by the Department	 As needed As needed By date given By date given
	LSS Notices	BWC: LSS – New Applications* LSS – Status Changes* MCO:	 Weekly Weekly
	MCO Business Unit	BWC: Other information as needed MCO: Information requested by the Department	 As needed By date given
	MCO Business Unit: DoDM-MoD documents	BWC: Responses to appeals* Other information as needed MCO: SOC Code files* Appeal spreadsheet* Appeal documentation (under 100 pages)*	 As needed As needed 5th of the month By date given By date given
	MCO Business Unit: Open Enrollment	BWC: Weekly list of gained/lost policies* TENS billing history for claims gained* MCO: Transfer spreadsheets*	 Weekly during OE Once per OE Once per OE

Library Name	Folder Name	Documents	Deadline/ Timing
	MCO Business Unit: Request for Review – Appeals	BWC: Responses to set-off appeals* Responses to capacity request for review* Other information as needed MCO: Set-off appeal spreadsheet* Capacity request for review spreadsheet* Appeal documentation (under 100 pages)*	 As needed As needed As needed By date given By date given As needed
	MCO Business Unit: Proof of Compliance with Training Hours	BWC: Other information as needed MCO: Documentation to show compliance with required training hours*	 As needed October 31st
	MCO Business Unit: Weekly Detail Files	BWC: Detail of weekly capacity calculations* 148 Data Accuracy FROI Timing FROI Turnaround 837 Data Accuracy Bill Timing POR/CMCC List of IW currently receiving specific forms of compensation* MCO:	 Weekly Weekly
	Medical Billing and Adjustments	BWC: List of bills for pending settlement claims* MCO: Information requested by the department	 Weekly By date given

Library Name	Folder Name	Documents	Deadline/ Timing
	Pharmacy	BWC: Information relating to the administration of the pharmacy program Other information as needed MCO: Information requested by the Department	 As needed As needed As needed
	Provider Relations	BWC: Other information as needed MCO: Information requested by the department	 As needed By date given
	Public Information	BWC: Responses to public information requests submitted by the MCO*	 As needed
	RTW-OSDD Letters	MCO: File containing information related to RTW Letters sent by the MCO*	 Monthly
	Transitional Work Program	BWC: Employers participating in the TW Bonus program Employers with a TW Grant	 Semi-Annual As updated
	Voc Rehab	BWC: Other information as needed MCO: Information requested by the department	 As needed By date given

*Including, but not limited to the files flagged with the asterisk, BWC and the MCO should save the file to their computer/server and delete it from the portal within 90 days.

BWC will add additional folders as required/requested to the MCO Site.

4. CCT Contacts

Each claim filed with BWC is assigned to a CCT based on employer or injured worker location. BWC will notify the MCO via 148 Electronic Data Interchange (EDI) of the claim assignment information (team number) and claim service specialist name when BWC acknowledges receipt of the injury. The MCO shall assign cases to appropriate staff no later than 5:00 P.M. Eastern Time the next Business Day after the MCO's FROI

Receipt Date. The MCO shall notify BWC of case assignment within 2 business days. However, this requirement shall not apply to claims gained by the MCO during the 2012 Open Enrollment period, provided the case manager/case contact information for these claims is submitted to the Bureau in accordance with the schedule provided by the Bureau.

The CCT is the MCO's primary point of contact for all claim issues. Together, the MCO and the CCT can discuss issues in the claim and bring those issues to a successful resolution. The CCT is also the MCO's resource regarding BWC claims law and policy.

Communication between the MCO and the CCT will insure that accurate medical and accident description information is exchanged, which will reduce the time it takes to resolve claim issues. MCO and their vendors or subcontractors shall provide toll free phone and fax number to external customers. The MCO's toll free fax number published to providers must forward to the medical repository. The MCO and their vendors or subcontractors shall use only fax machines with date/time indicators (showing either A.M./P.M. or military time), and shall leave the date/time indicators on at all times. The MCO shall include by programming it into the fax machines the MCO name on receipt and send fax functions. The MCO shall use MCO specific date stamps with MCO name clearly stamped on all documents received.

Customer service telephone lines must be staffed during Normal Business Hours, Monday through Friday 9:00 A.M. through 5:00 P.M. Eastern Time. The MCO shall acknowledge all inquiries including BWC inquiries, (via e-mail, fax, phone, mail) within **2 business days of receipt and initiate action for resolution to the inquiry within 5 business days. MCOs are expected to track all inquiries through to resolution and report back to the inquirer as to the resolution.**

MCOs Internet e-mail addresses should be listed on the specific MCO page of the portal

BWC CCT members can be e-mailed via the Internet at this address: first name.last initial.number@bwc.state.oh.us (ex.:John.D.1@bwc.state.oh.us.). All MCO staff who address claim related inquiries shall have access to Ohiobwc.com.

5. MCO Notes

a. Overview

Notes are a chronological record of events and activities in a claim. Accurate notes reflect the progress of the claim and provide a quick and easily accessible summary of claim activity. As part of the Claims Staffing process, all claims management services are integrated on Customer Care Teams. These integrated services include claims specialists, employer management, injury management support and MCOs. As part of the integration of services process, MCOs are required to submit their notes to BWC. Initially, notes were to be viewable to only BWC and MCO staff.

b. Submitting Notes to BWC

Effective Oct. 18, 2004, MCO notes created from that date forward were shared with BWC for BWC viewing through V3 notes. MCO notes created before Oct.18, 2004 were not to be sent to BWC. MCOs must have a daily process for submitting notes. MCO notes must be submitted within one business day of creation. In the case of new claims, notes must be submitted within one business day of claim number receipt. Notes submitted with a creation date more than 10 calendar days prior to the submission date will be rejected.

MCOs should not send notes received from previous MCOs (i.e. notes from claims transferred through open enrollment or policy number changes). Previous MCO notes should have already been submitted and viewable via V3 and Ohiobwc.com.

Notes related to Fraud should not be submitted in the MCO Notes file. The MCO should follow established processes for reporting suspected Fraud.

c. Note Procedures

MCOs will continue to enter notes according to their medical management policies and procedures as required by URAC with three notable exceptions:

1. If an MCO or BWC staff name is used in the notes, it should only contain first name and last initial.
2. Notes should not contain the BWC servicing provider number as BWC sometimes assigns a servicing provider number to an individual provider based on his/her social security number with a two digit (-00) suffix. Care should be taken in documenting phone numbers and fax numbers.
3. Existing notes cannot be appended after they have been submitted to BWC. A new note will need to be created because each note will have a system assigned unique identifier when it is submitted to BWC.
4. Cutting/copying and pasting content from e-mails into notes is quick and convenient. However, to ensure consistency and easy understanding for all parties reading the note, the following guidelines must be followed:
    - Identify the author of the e-mail - be sure to only use first name and last initial;
    - Explain why the e-mail is pasted in notes;
    - To avoid duplicates, make sure the content from the e-mail is new information not already available in V-3 notes (BWC entered) or imaging.

MCOs shall use the following standardized note titles, or a title of equivalent meaning:

- Initial Customer Care Plan (CCP)
- Customer Care Plan Update / Staffing
- Contact with Injured Worker (IW)
- EIA Support Materials
- Contact with Provider
- Contact with Employer
- Contact with Attorney of Record (AOR)

- Contact with Third Party Administrator (TPA)
- C–9
- C-9 Negotiation
- Proactive Allowance Clinical Findings
- Claim Reactivation Clinical Findings or just Claim Reactivation. MCO Medical Director Review
- Contact with BWC
- Remain at Work (RAW)
- Vocational Rehabilitation
- Alternative Dispute Resolution (ADR) – MCO Level
- ADR Negotiation Attempt
- ADR Dispute—Call IW for Exam Date
- ADR IME
- ADR File Review Scheduled
- ADR Resolved
- Peer Review/ Independent Medical Examination (IME)
- Lump Sum Settlement (LSS)
- Return to work (RTW)
- Inpatient hospital review
- Specialist Consultation
- BWC/IC hearing order acknowledgement
- Medical received/reviewed
- MMI notification
- Change of Physician
- Exam follow up with POR
- Billing Issues
- Ecodes
- MCO Rx Regimen Review
- MCO Rx Regimen Intervention
- MCO On-Site CM Visit

The title in V3 when a note is submitted without a title will be "MCO Note Sent Without Title."

d. Quality Assurance

Accurate notes reflect the progress of the claim and provide the reader with a quick and easily accessible summary of claim activity. Notes should be written in a professional manner and contain ***objective*** statements, such as facts and actions and observable behaviors, without bias. Notes should not contain ***subjective*** statements, such as opinions, perceptions or drawn conclusions. MCO notes must provide evidence that the MCO contacted or attempted to contact the injured worker, provider and employer in the course of creating a RTW plan which includes the RTW expectations.

As a general guideline, notes should:

- Contain only factual information. They will not include editorials or hearsay.
- Be written in a logical and sequential order.
- Be direct and to the point. The use of jargon and abbreviations should generally be avoided.
- Only contain information that is relevant to the claim.
- Contain an explanation of any decisions made by the MCO.
- Be entered the same day as the action being described.
- Cite all contacts. BWC contacts (e.g. team nurse) should be cited by first name and last initial (e.g. John D. for John Doe). MCOs have the option of citing their staff names by first name and last initial. External contacts should be cited by first and last name along with their relationship to the IW or employer (e.g. Called IW and spoke to John Doe, the IW's brother.)
- Not contain BWC servicing provider numbers. Care should be taken in documenting phone numbers and fax numbers.
- Not duplicate information from a previous note submitted to BWC.
- Contain proper English and grammar.
- Each note should be informative, accurate and easy to understand.

e. Viewing MCO Notes

The MCO notes are loaded intoV3 notes in BWC received date order. During the transition period, after the MCO notes were loaded in V3, V3 users, BWC Internal website users, the Industrial Commission and Attorney General's office had access to view MCO notes. The MCO also had access to view its notes through Ohiobwc.com. Authorized providers and external parties gained access to view MCO notes on Jan. 18, 2005. The MCO Notes appear in V3 and BWC's website as text only. MCO notes do not necessarily display in the same format as it appears on the MCO system. MCO notes are accessible on EDA.

f. Deleting MCO Notes

After the MCO notes have been successfully loaded in V3, all V3 users will have access to view the note. Upon viewing the MCO's notes, if the Customer Care Team Manager (CCT) determines that the note(s) may be inappropriate, the issue will be referred to the SOM for review. If the SOM review agrees that the note is inappropriate, the V3 Support Team Manager will be contacted to review the note(s) and determine if the note needs deleted.

Currently, BWC does delete selected notes from V3; however, it is not a common occurrence. The determination of an inappropriate note is not based on spelling or grammar errors. Rather, it is deleted because it contains references that are unprofessional, can be construed as inflammatory or harmful to an individual, not related objectively to the management of the claim or reflect personal feelings regarding a contact that has been made. The *V3* Support Team Manager, the MCO Business Council

Representative and MCO Business and Reporting Unit Representative will coordinate the determination to delete a note.

g. Rejected MCO Notes

If a note is rejected because the MCO no longer manages the claim, the MCO must ensure that substantive information is communicated to the new MCO. If a note is rejected because the claim has been combined, the note under the surviving claim should be resubmitted if it contains substantive information.

Notes submitted with a creation day more than 10 calendar days prior to the submission date will be rejected and should be resubmitted according to the procedures detailed in the Information Systems Documentation.

C. CLAIM MANAGEMENT AND THE CLAIM LIFE CYCLE

1. Categories of Claims

Claims are divided into two (2) categories: **lost-time or medical-only**. A **lost-time claim** is one in which an employee has lost eight (8) or more calendar days from work or the work-related injury resulted in an amputation or death. A **medical-only claim** is one in which an employee has lost seven (7) or fewer calendar days of work due to a work-related injury. When submitting ICD-9 codes for these conditions, include the coverage code as "lost-time" to ensure that the claim is assigned to the appropriate Service Office.

Back and knee injuries should not automatically be assigned a lost-time coverage code simply due to the nature of the injury.

2. Types of Claims

Claims are further defined as being either an **injury, death,** or **occupational disease (OD)**.

An **injury,** as defined in R.C. 4123.01(C), includes any injury, whether caused by external accidental means or accidental in character and result, received in the course of, and arising out of, the injured worker's employment.

An **occupational disease** as defined in R.C. 4123.01(F) as a disease contracted in the course of employment, which by its causes and the characteristics of its manifestation or the condition of the employment, results in a hazard which is distinguishable by the employee's employment in character from employment generally; and, the employment creates a risk of contracting the disease in greater degree and in a different manner from the public in general. **An OD claim must be reported to BWC according to the claim type – medical only or lost time.**

BWC will continue to manage both legal and medical treatment issues for the following claims as they are not considered part of HPP:

- Federal Black Lung
- Marine Fund

BWC's approach to effective claim management is separated into specific phases. These phases are referred to as the *life cycle of a claim*. The life cycle of a claim is a continuous process that reflects the path of a claim until resolution.

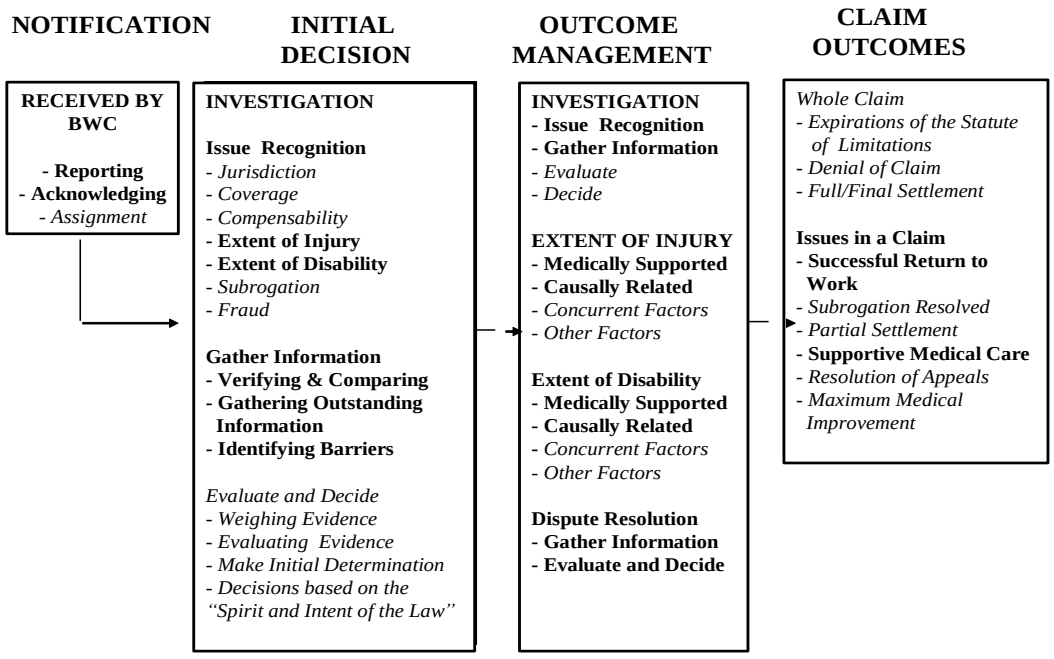
3. Claim Life Cycle Phases

The claim life cycle is comprised of four distinct phases, which are:

- ✓ **Notification**
- ✓ **Initial Decision**
- ✓ **Outcome Management**
- ✓ **Claim Outcome**

The following information outlines each phase of the claim life cycle, the activities involved within each phase and BWC's time requirements for completing certain activities. Also included is information required from the MCO to assist the CCT in completing certain activities in each phase.

HPP LIFE CYCLE OF A CLAIM



a. NOTIFICATION PHASE

1) Reporting

The MCO is responsible for notifying BWC of a new injury or occupational disease. MCOs may take the necessary information (on the FROI form) over the telephone or ask for a completed FROI form to be faxed to them. The date to be reported for the "Date Reported to MCO" field on the initial 148 shall be the actual day the MCO receives the first report of injury notification. The FROI Receipt Date is "the MCO's Receipt Date for the initial notification of an injury, regardless of the number of mandatory data elements the initial notification contains." Properly reporting this data element will ensure

consistent and accurate measurement of all MCOs. The MCO shall submit the FROI electronically via the initial 148. However, the MCO may submit FROIs to BWC via BWC's website (www.bwc.ohio.gov) in exceptional circumstances. Examples of exceptional circumstances include, but are not limited to:

- The MCO received a FROI for an employer not assigned to the MCO; or
- The IW has an immediate need for a claim number to be assigned to be able to have a prescription filled.

The MCO shall educate and encourage providers, employers and injured workers to notify the MCO immediately of an alleged accident/injury. MCOs shall advise providers that they will receive a claim number immediately when they file a FROI online. Each MCO, in partnership with BWC, is required to educate employers on the proper completion and filing of FROIs.

BWC will accept a notice of injury from any source. If an injury is reported to BWC from a source other than the MCO, BWC will generate a notice via EDI to the appropriate MCO within one business day. The MCO is responsible to investigate and ensure that additional data elements are submitted.

The following grid was designed to define the required data elements when filing the FROI electronically on BWC's website.

Required data elements to file FROI on BWC's website	**Injured Worker**	**Employer**	**Provider**
Injured worker name	yes	yes	yes
Injured worker social security number	yes	yes	yes
Injured worker mailing address	yes	yes	yes
Injured worker phone number	yes	yes	yes
Date of birth	yes	yes	yes
Date of injury	yes	yes	yes
Gender	yes	yes	yes
Occupation or job title	yes	yes	yes
Causality indicator	no	no	yes
Accident description	yes	yes	yes
Type of injury	yes	yes	yes
Body part affected	yes	yes	yes
Employer policy number *	yes	yes	yes
Days off indicator	yes	yes	yes
Place of accident	no	yes	no
Date hired	no	yes	no
Coverage code (Lost Time or Medical Only)	no	no	no
Date reported to MCO	no	no	no

Other reporting methods include:

- Phone
- Fax
- Mail
- In person

While applicable, BWC will validate the MCO's compliance with submitting 70% of their FROI's within 3 FROI business days and 100% within 5 FROI business days. The FROI Turnaround and FROI MCO-BWC % - 0-3 days and FROI MCO-BWC % - 4-5 days measures will continue to be included in the MCO Summary. The MCO Receipt Date of the FROI is part of the audit universe and, as such, may be audited by BWC's Internal Audit Division during an audit.

The MCO Audit Department will honor an MCO's request to review certain files on-line. This requires that a computer be designated for that auditor during the duration of the audit and that the auditor have the ability to print specific pages as required. Files reviewed for the FROI data accuracy are excluded from the on-line review. They must be available in hardcopy format.

The 148 data elements descriptions are Required and Situational. Situational data elements fall into four categories: S0, S1, S2, and S3. For actual data elements and their designation, refer to Appendix B Information Systems Documentation of the MCO Agreement. All of the 148 data elements are measurable and are subject to audit by the MCO Audit Department.

- Required data elements - Must be submitted no later than 3:00 P.M. Eastern Time the third FROI Business Day after the MCO's FROI Receipt Date for 70% of the 148s and the fifth FROI Business Day after the MCO's FROI Receipt Date for 100% of the 148s. Any missing element(s) will result in rejection, as BWC cannot assign the claim number without all of the required data elements.

The MCO shall:

- Submit the most accurate and complete information available within the timeframes established above;
- Exercise due diligence in attempting to gather the required data elements and document its efforts in a retrievable format in its case management notes system;
- Obtain missing and/or incomplete information and resolve conflicting information prior to submitting the initial 148 to BWC;
- Make a reasonable attempt to contact the injured worker to obtain accident description information;
- Make a reasonable attempt to contact the employer to verify the claim and obtain employer certification of the claim.
- Submit 148 transactions indicating those claims which have missed eight or more days of work are lost time claims regardless of whether indemnity compensation has been paid.

i) EDI 148 – FROI Causality Indicator Clarification

No matter what value is sent by the MCO for the "Causality Indicator" (data element 46 in the business rules matrix) on the 148, BWC expects that the MCO has documentation on file to support that value. The primary source for the "Causality Indicator" is the provider. The MCO must also have documentation on file to support that the MCO made reasonable attempts to obtain causality information from the provider prior to sending in the initial 148. It is expected that the MCO will not submit an initial 148 until efforts have been made to contact the provider to obtain causality information. If the MCO is unable to obtain the causality information from the provider after reasonable attempts, the MCO may submit "U" with an explanation in the 'nature of injury' field.

Appendix B - Information Systems Documentation of the MCO Agreement contains the Business Rules Matrix and Data Definitions including the values described below that must be submitted by the MCO.

The values "Y" and "N" now have definitive meanings, with no additional explanation required. Any cases where "Y" or "N" cannot be used must be reported with a "U" (undetermined). When the value "U" is sent, additional information must be sent in the "Nature of Injury" (data element 42 in the business rules matrix). The examples listed below are not all-inclusive.

Examples for uses of the Causality Indicator:

- "Y" - The provider believes the injury was causally related to the patient's employment.

- "N" - The provider does not believe that the injury was causally related to the patient's employment.

- "U" - The provider would not give an opinion as to whether or not the injury was causally related to the patient's employment. (A note should be sent in the "Nature of Injury" to state that the provider declined to establish a causal connection between the injury and the IW's employment.)

- "U" - The provider did not give an opinion as to whether or not the injury was causally related to the injured employee's employment. (A note should be sent in the "Nature of Injury" to state that the provider did not document causality and the MCO has attempted on more than one occasion to obtain the information directly from the provider, but was unsuccessful.)

- "U" - The injured worker did not seek medical treatment. (A note should be sent in the "Nature of Injury" stating that the IW did not seek medical treatment.)

  Again, the examples provided above for notes to be sent with the value of "U" are not all-inclusive.

ii) Injured Worker Address

The IW address reported by the MCO on the FROI is used in BWC's initial claim correspondence. Consequently, it is important that data elements 8 through 12 are accurate and comply with US Postal Standards. Therefore, the MCO shall make sure that the address submitted on the initial 148 complies with US Postal Standards. The MCO Audit Department will use the postal standard to evaluate accuracy of these data elements. If there are perceived discrepancies between what the IW reported, and what was submitted on the FROI, data will be considered accurate when the MCO demonstrates that changes made were in compliance with postal standards. If the MCO's system does not have software to ensure compliance with postal standards and the MCO wants to verify compliance, the following website can be used: http://www.usps.gov/ncsc/lookups/lookup_zip+4.html.

iii) Nature of Injury

Note: MCOs shall use the "text" field in the "nature of injury" box to provide any additional information provided by the treating provider, or, to clarify information regarding the "causality" indicator. Examples include: a) If the MCO is unable to verify causality with the treating provider, or b) if no treatment was sought, or c) if information is received from the employer via the First Report of Injury. The primary source for the "Nature of Injury" is the provider. The MCO must submit the source if it is other than the provider. The MCO must make reasonable attempts to obtain the required information from the provider. This information will greatly assist the CCT in the investigation of the claim allowance decision.

This data element is used for 2 purposes: This data element is a mandatory data element and should be sent on the initial 148. If this data element is omitted on the initial 148, the transaction will not be rejected. However, audits will be used to verify that the MCO is submitting it on the initial 148. This information will be used in comparison to or to validate the report the injured worker provided.

Definition 1: Description of the objective and subjective findings made by the physician who initially treats the injured worker. Data element may also include any **additional** details regarding the accident description that are provided by the physician or healthcare provider, if they have not been communicated by the injured worker in the accident description data element.

Application 1: The purpose of this data element is to capture the best information regarding the nature of injury. At times it is necessary to look beyond the actual FROI form in order to accurately report the Nature of Injury. The description of the nature of injury should primarily come from the physician who initially treated the injured worker. The information typically is found in the "Treatment Info." section of the FROI. This should be the primary source for the information

submitted in this field; however, it may be supplemented with additional information obtained from other medical documentation or another source.

If the MCO is unable to obtain information from the treating physician, the MCO may (the information is listed in order of importance):

1. Send information from any other health care professional who described the injury.
2. Then, if that is unavailable, send the Injured Worker's statement (from the Injury/Disease/Death Info. Section of the FROI, for example),
3. Otherwise, send the employer's statement,
4. Or, lastly, send a witness' statement.

The MCO must designate the source of the information in numbers 2-4 (e.g. "per employer").

Example: "Fractured first joint of left index finger."

Definition 2: If the Causality Indicator value in Data Element #46 is "U", a description must be entered to document the reason for the Undetermined "U" value in addition to the nature of injury information described above.

Application 2: This data element is also used to document the reason the causality indicator submitted was a "U" (undetermined) value. The MCO's system should not generate an automated text message in this field. The MCO should document what they determined while trying to identify the correct causality indicator to submit to BWC.

iv) Accident Description

The MCO shall submit to BWC the accident description verbatim as reported on the first report of injury documentation which may/may not be by the injured worker. The primary source for the "Accident Description" is the injured worker. However, the accident description may be submitted by any source for a select number of ICD-9 codes. Refer to the section on Minor **Injury ICD-9 codes** below for a list of those minor injury claims:

- the MCO is not required to contact the injured worker for the description, **unless** there is missing, incomplete or conflicting information.
- The MCO may submit the accident description as reported by another source.
- For any source other than the injured worker, the MCO must identify the source (e.g., "per provider…").

For all claims having the primary or only ICD-9 code that does **not** appear on the Minor Injury ICD-9 Code section below, the MCO must make reasonable attempts to obtain the information from the injured worker prior to submitting the initial 148 to BWC. If the accident description exceeds 264 characters, the MCO may submit the remainder in the Nature of Injury field on the initial 148, as long

as it is properly documented as such. The MCO may also contact the CSS to inform him/her of the additional accident description information.

c) Lost-Time and Medical-Only Claims

Lost-time claim numbers are assigned to claim applications where the injured worker lost eight (8) or more days from work, or the injury resulted in an amputation, or death. When submitting ICD-9 codes for these conditions, include the coverage code as "lost-time" to ensure that the claim is assigned to the appropriate Service Office.

Back and knee injuries should not automatically be assigned a lost-time claim number simply due to the nature of the injury.

d) Causality

If an MCO believes that the request for services is not reasonably related to the industrial injury, medical evidence in the form of a physician review (in writing) or an IME must be provided to support this contention. The IME must be completed by a "like" specialty provider and the provider may not be of the same practicing group within the MCO.

g) E causation codes on FROI

To facilitate gathering the needed information, BWC has updated the FROI form (FROI-1) to include a field for the provider to submit the E-code, if available. We have also updated bwc.ohio.gov to include a field for the E-code when the FROI is filed on-line.

If the E-code is on the FROI form or if, within one week of the claim being filed with BWC, the MCO receives medical/bills that contain the E-code, MCOs are to send it to BWC in a note utilizing the new E-code note title. The requirement to submit the E-code if received on medical or bills applies to all new claims filed regardless of method (web, MCO, service office, etc.).

MCOs are not required to actively pursue obtaining the E-code but must send it in a note per the above paragraph.

2. Acknowledgment

BWC must notify the parties in the claim of receipt of the claim within seven (7) days. However, BWC systematically provides notice within one business day of receipt when the claim is entered into BWC's computer system. Parties to the claim include:

- Injured Worker;
- Employer;

Authorized Representatives

The initial notification letter includes the claim number, assigned CCT, MCO information and other important injury information. The MCO will receive acknowledgment information via EDI (148) transmission.

Note: BWC's Version 3 system does not allow two claims to be entered with the same social security number, same policy number and same date of injury. If an injured worker has two

accidents in one day with the same employer, the second claim appears to be an exact duplicate and will not be accepted electronically from the MCO or bwc.ohio.gov. The MCO must file the first claim submitting all expected data elements in the Information Systems Documentation, then file the second claim missing a data element (e.g. ssn). The MCO must work with the customer care team leader filing the claims. Once the second claim is filed, team leader will update the second claim manually and notes in both claims will be updated to clearly explain that the claims are not duplicates.

3. **Assignment**
   BWC's computer system will create a claim number and assign the claim to a CCT within 24 hours. CCT assignment is based on factors such as the employer or injured worker location. Lost-time claims are assigned to the CCT in the appropriate local Service Office. Medical-only claims are assigned centrally in Columbus unless based on Triage logic it is reassigned to the local Service Office for processing.

4. **Minor Injury ICD-9 Codes**
   For those claims having a minor injury ICD-9 code as their only or "primary" code, the injured worker need only be contacted for the accident description if there is missing, incomplete or conflicting information. Otherwise, the description as provided by another source may be submitted. Refer to "Accident Description" section above for additional information on the initial 148 to BWC. The following is a list of the minor injury codes. (NOTE: The examples below are not all-inclusive.)

	ICD										
Conjunctivitis											
	372.00										
	372.01										
	372.05										
	372.20										
	372.30										
Dermatitis											
	692.0	692.5	692.74								
	692.1	692.6	692.79								
	692.2	692.70									
	692.3	692.71									
	692.4	692.72									
Superficial lacerations/Open wounds											
	870.0	871.9	873.20	873.44	873.63	875.0	878.4	879.4	880.03	8820	893.0
	870.8	872.00	873.40	873.49	873.64	876.0	878.6	879.6	880.09	883.0	
	871.4	872.01	873.41	873.60	873.65	877.0	878.8	880.00	881.00	890.0	
	871.5	872.8	873.42	873.61	873.69	878.0	879.0	880.01	881.01	891.0	
	871.6	873.0	873.43	873.62	873.8	878.2	879.2	880.02	881.02	892.0	
Abrasions/friction burns											
	910.0	915.0									
	911.0	916.0									
	912.0	917.0									
	913.0										

914.0

Insect stings

910.4 915.4
911.4 916.4
912.4 917.4
913.4 989.5
914.4

Blisters/Superficial Foreign Body

910.2 912.6 915.2 917.6
910.6 913..2 915.6
911.2 913.6 916.2
911.6 914.2 916.6
912.2 914.6 917.2

Corneal Abrasions

918.0
918.1
918.2
918.9

Superficial Contusions

921.1 922.1 922.8 923.10 923.8 924.20
921.2 922.2 923.00 923.11 924.00 924.21
921.3 922.32 923.01 923.20 924.01 924.3
921.9 922.33 923.02 923.21 924.10 924.4
922.0 922.4 923.03 923.3 924.11

Foreign Body in the Eye

930.0
930.1
930.2
930.8
930.9

First degree Burns

940.0 940.9 941.14 941.19 942.14 943.12 943.19 944.14 945.10 945.15
940.1 941.10 941.15 942.10 942.15 943.13 944.10 944.15 945.11 945.16
940.2 941.11 941.16 942.11 942.19 943.14 944.11 944.16 945.12 945.19
940.3 941.12 941.17 942.12 943.10 943.15 944.12 944.17 945.13
940.4 941.13 941.18 942.13 943.11 943.16 944.13 944.18 945.14

b. INITIAL DECISION PHASE

The *Initial Decision Phase* focuses on the activities surrounding BWC's claim determination process. According to R.C. 4123.511, BWC has 28 days to complete the investigation and issue a decision on the claim's compensability. It is critical to obtain the necessary medical documentation from the MCO within seven days of the treatment, service or injury notification.

1. Issue Recognition

Issue Recognition is breaking a claim down into distinct and separate issues that are critical to the investigation and are specific requirements that must be considered to determine if a claim is compensable. These issues are:

- **Jurisdiction**
- **Coverage**
- **Compensability**
- **Fraud**

a) Jurisdiction

Jurisdiction is a legal issue referring to the time and place of the injury and involves the interstate jurisdiction of Ohio Workers' Compensation laws and the statute of limitations for filing claims. According to R.C. 4123.84, the injured worker has two years from the date of injury or death to report the claim. According to R.C. 4123.85, in occupational disease claims or death from occupational disease, the injured worker has two years from the date of the disability due to the disease began, or within such longer period not exceeding six months after diagnosis of the occupational disease, or within two years after death occurs.

b) Coverage

Coverage is a legal issue (R.C. 4123.01) involving a determination as to whether there is an employee/employer relationship between the injured worker and employer versus an independent contractor or volunteer. BWC determines coverage and relies on information supplied by the MCO to make such determinations.

MCOs shall attempt to contact the employer to verify employment and obtain claim certification. Employer verification and certification shall be electronically submitted to BWC. If an employer denies the presence of employer/employee relationship in the claim, the MCO shall document the denial in a note in the system and immediately contact the CSS via phone. The CSS shall conduct an investigation to determine coverage.

c) Compensability

Compensability is a legal and medical issue to determine if the following criteria are met as outlined in the law and supported by medical evidence. According to R.C. 4123.01:

- There must be an accidental injury or occupational disease;
- The injury must be physical in nature (psychiatric conditions, stress, exposure or natural deterioration in the absence of a physical injury are not compensable).
- The injury must have been sustained in the course of employment. This refers to the circumstances of the occurrence of the injury in terms of time, place and activities in which the employee was involved at the time of injury.
- The injury must arise out of the employment. A medical issue which involves the causal connection (relationship) between the injury and the circumstances of the employment. In most cases, the customer service specialist must have medical documentation from the MCO to support this criteria and make this determination.

d) Subrogation

BWC has the right of recovery from a third person or party for the cost of benefits paid or to be paid to an injured worker. It must be proven that the third party's negligence was a contributing factor in the cause of the accident or injury. Per R.C. 4123.93 and 4123.931, valid third party claims with **dates of injury** on or after April 9, 2003 can be subrogated. Subrogation rights are never **waived**. To do so could forever prevent BWC from making a subrogation recovery demand against the responsible party if such rights have been waived.

Negotiation of a subrogation recovery should never occur between the Claim Service Specialist and any party to the subrogation action. Requests to negotiate BWC's demand should be referred to the BWC Law Department's Subrogation Unit for handling of the recovery.

See Chapter 8 of the MCO Policy Reference Guide for additional information on subrogation reimbursement.

e.) Fraud

The CCT and the MCO will partner to recognize potential *fraud* issues in a claim during the investigation.

2. Gathering Information

The MCO is the primary entity responsible for data collection from IWs, employers and providers to support BWC claim determination. Following notification of a claim, the MCO shall aggressively gather pertinent initial medical documentation from all treating providers to support BWC's initial determination. The MCO sends this information to the Medical Repository via BWC's mail line or the service office imaging fax line as noted in chapter 1. All documents in the claim are legal documents. MCOs must date stamp all documents (including FROIs, provider bills, etc.) using the actual Receipt Date as defined in Appendix G of the MCO Agreement. The receipt date is the date the MCO receives any documents or information related to a claim including but not limited to FROIs, provider bills, C-9 or alternative treatment plan, customer inquiries, ADR, etc. MCOs may ask providers to supply medical documentation; providers must comply with this request within five (5) business days per their Provider Agreement. NOTE: The provider must return the form C-9-A and any additional supporting documentation to the MCO within 10 business days as indicated in chapter 3.

In addition to gathering initial medical documentation, the MCO is responsible for proactively gathering pertinent medical documentation throughout the life cycle of the claim.

By filing a claim for workers' compensation benefits, the injured worker gives release to BWC or anyone working for BWC to access information related to the claim. Consequently, submitting medical reports to either BWC or an MCO **does not** require a release of information form signed by the injured worker. In instances where a signed release form is desired, the injured worker can sign the First Report of Injury (FROI) form or BWC's Authorization to Release Medical Information (C-101) form. Some

providers utilize a Financial Release form, which would suffice. The MCO will forward medical or vocational information/documentation requested by the CCT within one business day of the request or receipt of the information/documentation.

a) Initial Contacts

Information and/or documentation for any issues identified during *Issue Recognition* should be obtained in a timely manner. Within three (3) business days of receipt of a claim, the CCT may contact the MCO. The CCT will attempt to contact the MCO first to gather any information received since the initial 148 transmission, and to avoid duplication of efforts when calling the injured worker and employer. The MCO is responsible for collecting data to support claim determination and is a valuable resource to the CCT. The MCO shall proactively gather information to facilitate and support the initial decision. The CCT shall discuss with the MCO any needed information in order to make a claim determination.

b) CCT/MCO Responsibilities

CCT:	**MCO:**
Partner with MCO to verify and compare information when needed; Staff with MCO; Gather additional information; Discuss and resolve issues; Obtain disability information; Obtain wage information; Inform of next steps to be taken in the claim and answer questions.	Gather and verify initial information; Staff with CCT; Gather additional information; Discuss and resolve issues; Obtain and forward disability information to CCT; Obtain and forward medical documentation to CCT; Coordinate and forward treatment plan to CCT; Set RTW expectations and outcomes and identify barriers to RTW; staff with CCT as appropriate.

It is critical that the MCO gather and provide medical evidence to support the initial decision in a timely manner.

c) Medical Evidence

Medical evidence may include:

- Emergency Room Report;
- Physician Statement;
- Specialist Report;
- Operative Report;
- Diagnostic Report;
- X-ray, MRI, CAT Scan;
- Accident Report;

- Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease (C-9)
- Physician's Return to Work Report (MEDCO-14)
- Physician's Office Progress Notes.

Signatures on Medical Evidence:

- An original or stamped signature on a physician report is acceptable.
- Medical reports signed by a healthcare provider's authorized representative are acceptable. The POR or treating physician's designee will sign for the POR or treating physician and initial. For example, **the physician of record or treating physician must sign a C-84.** An advanced practice nurse (nurse practitioner or clinical nurse specialist) (APN) and/or physician assistant (PA) working in collaboration with the physician may not sign a C-84, as they may not certify compensation. However an APN and /or PA may be a designee and sign the POR's name and initial. *
- An advanced practice nurse (nurse practitioner or clinical nurse specialist) (APN) and/or physician assistant (PA) signature is acceptable as long as the conditions diagnosed or treated, and services rendered are within the APN's and/or PA's scope of practice. An APN and/or PA may sign a C-9. An APN and /or PA may not sign a C-84, as they may not certify compensation. **A C-84 must be submitted by the physician of record or treating physician.**
- BWC accepts EDI transmissions as medical evidence in making claim determinations. However, if a claim is contested, BWC must obtain the hard copy medical report with a provider's signature from the MCO.
- A First Report of Injury (FROI) may be signed by anyone but a signature is not required. **
- A Physical Therapist (PT) or Occupational Therapist (OT) may sign a C-9 for therapy services; however, C-9s signed by a PT or OT must be accompanied by a prescription from the POR or other approved treating provider licensed to practice medicine, osteopathy, chiropractic, mechanotherapy, dentistry, podiatry, or nursing as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse midwife, or certified nurse practitioner. ***

The following grid identifies provider types whose signature can be accepted on medical evidence.

Provider Type	Request for Temporary Total Compensation (C-84)	Physician's Report of Work Ability (Medco-14)	Request for Medical Service Reimbursement or Recommendation for Additional Conditions (C-9)	ADR Appeal to the MCO Medical Treatment / Service Decision (C-11)	First Report of an Injury, Occupational Disease or Death (FROI) **

(POR) = MD, DO, DC, DDS, DMT, DPM, & Psychologist	YES (Must be signed by the POR or treating physician*)	YES (Must be signed by the POR or treating physician*)	YES	YES	YES
APN	NO	NO	YES	YES	YES
PA	NO	NO	YES	YES	YES
Optometrist	NO	NO	YES	YES	YES
Audiologist	NO	NO	YES	YES	YES
LISW & LPCC	NO	NO	YES	YES	YES
LSW & LPC	NO	NO	NO	YES	YES
Physical Therapist (PT)	NO	NO	YES (Must be accompanied by a prescription ***)	YES	NO
Occupational Therapist (OT)	NO	NO	YES (Must be accompanied by a prescription ***)	YES	NO
All other non-physician providers	NO	NO	NO	YES	YES

If the relevant information is not in the MCO file, it is the MCO's responsibility to contact the provider to obtain it and send it on to BWC. If documented medical evidence doesn't exist, (e.g., the IW never sought treatment) the MCO should inform the BWC CCT of this. The following are instances the CCT will likely request hard copy medical documentation:

- Initial claim determination (complex or questionable injuries/issues and disputed issues such as employer contesting claim)
- Subsequent determination (additional allowances)
- Appeals
- Extent of disability exams
- Therapeutic drug class utilization reviews
- Reactivations (questionable causal relationship)
- Payment of compensation

1) Lost Time Claims

MCOs are required to automatically send all hard copy medical evidence gathered from the POR/treating provider to BWC upon receipt, prior to initial claim determination. This information will aid the lost time CCTs in making accurate, timely initial claim determinations. If no information is received from the MCO within 3 days of BWC's receipt of the initial 148, the CCT will contact the MCO (via phone, fax, email or correspondence) to request the needed information. If the MCO indicates it is unable to obtain the needed information or does not provide the information within 3 days of BWC's receipt of the initial 148, the CCT will contact the MCO directly for the needed information. Once the initial claim determination is

made, automatic routing of ALL hard copy medical documents from MCO to BWC is not required. Rather, the MCO will forward hard copy medical evidence upon request by BWC CCT for issues of compensability, statutory medical examinations or therapeutic drug classification utilization reviews, hearing preparation or as an attachment to the C-9 to request additional claim allowance consideration.

2) Medical Only Claims

MCOs are required to automatically send all hard copy medical evidence gathered from the POR/treating provider to BWC upon receipt, prior to initial claim determination for a select group of ICD codes. These ICD codes comprise BWC's top 30 ICD-9s as identified in the Diagnosis Determination Guidelines. This information will aid the Medical Only MCS in making accurate, timely initial claim determinations.

The following minor injuries *(always medical-only claims)* do not necessarily require medical evidence for the CCT to determine if the claim is compensable:

- First degree burns, less than 10 percent of the body;
- Superficial lacerations/contusions;
- Insect stings;
- Minor animal/human bites;
- Superficial foreign body in eye;
- Corneal abrasion;
- Conjunctivitis;
- Dermatitis;
- Blisters;
- Superficial injury/abrasion

This does not mean, however, that the MCS will not contact the MCO for medical evidence. Depending on the issues that arise during the MCS' investigation of a claim, the MCS may need to gather any medical evidence that the MCO has in their possession and it is the responsibility of the MCO to obtain the data collection should it become necessary. These claims like any other claim groups, require hardcopy medical evidence should the claim be disputed to the Industrial Commission (IC). A claim cannot be sent to be scheduled for IC hearing until the MCS obtains the hardcopy medical evidence (if treatment was sought), or, confirms with the MCO that the injured worker did not seek any treatment. Upon assignment of the claim to the medical claim specialist (MCS), a C63 V3 correspondence letter may be generated identifying what additional information is needed to make a claim determination. **The C63 letter will not be sent for BWC's 30 ICD-9 codes as identified in the Diagnosis Determination Guidelines.** If no information is received from the MCO within 3 days of BWC's receipt of the initial 148, the MCS will contact the MCO (via phone, fax, email or correspondence) to request the needed information. If the MCO indicates they are unable to obtain the needed information or does not provide the information, the MCS can contact the provider directly for the needed information.

The ICD codes requiring medical evidence when filed as a medical only include:

ICD code	Description
354.0	Carpal Tunnel Syndrome

722.0	Herniated Cervical Disc w/ or w/o radiculopathy; Cervical Disc Displacement w/o myelopathy
722.10	Herniated Lumbar Disc w/ or w/o radiculopathy; Lumbar Disc Displacement w/o myelopathy
722.11	Herniated Thoracic Disc w/ or w/o radiculopathy; Thoracic Disc Displacement w/o myelopathy
722.2	Disc Displacement NOS; Bulging Disc; Discogenic Syndrome
723.1	Cervicalgia (not eligible for BWC claim allowance)
723.4	Cervical Radiculopathy; Cervical Radiculitis; Cervical Neuritis
724.2	Lumbago (not eligible for BWC claim allowance)
724.4	Lumbosacral Radiculopathy; Lumbosacral Radiculitis; Lumbosacral Neuritis
726.10	Rotator Cuff Syndrome
726.2	Impingement Syndrome
726.31	Medial Epicondylitis
726.32	Lateral Epicondylitis
727.04	Radial Styloid Tenosynovitis; DeQuervain's Tenosynovitis
727.05	Tenosynovitis of hand and wrist
729.1	Myalgia and Myositis, NOS; Myofacial Pain Syndrome; Fibromyalgia; fibromyositis; Post Traumatic Fibromyalgia; Muscle Strain, third degree
739.0-.9	Nonallopathic Lesions; Intersegmental Dysfunction; Subluxation
836.0	Tear of Medial Cartilage or Meniscus of knee
840.0-.9	*Sprains and strains of shoulder and upper arm
841.0-.9	*Sprains and strains of elbow and forearm
842.00-.09	*Sprains and strains of wrist
842.10-.19	*Sprains and strains of hand
843.0-.9	*Sprains and strains of hip and thigh
844.0-.9	*Sprains and strains of knee and leg
845.00-.09	*Sprains and strains of ankle
845.10-.19	*Sprains and strains of foot
846.0-.9	*Sprains and strains of sacroiliac region
847.0-.4	*Sprains and strains of other and unspecified parts of back
848.0-.8	*Other and ill-defined sprains and strains
840.4	Rotator Cuff Tear

*Usually no specific diagnostic test exists. Establish causality utilizing mechanism of injury, IW history and complaints based on collection of data and information by the MCO.

MCOs are also required to send hard copy medical evidence upon request by MCS for other diagnoses when the need arises. Situations that may warrant a MCS to request hard copy medical evidence to establish initial claim determination (per ICD-9-CM) include:

- Issues of jurisdiction;
- Coverage;
- Course of employment;
- Diagnosis description inconsistent with accident description (mechanism of injury) causal relationship;
- Therapeutic drug classification utilization reviews, or other disputes.

Once the initial claim determination is made, automatic routing of hard copy medical documents from MCO to BWC in medical only claims is not required. Rather, the MCO will forward hard copy medical evidence upon request by BWC MCS or as an attachment to the C-9 to request additional claim allowance consideration.

Hard copy documentation is required to schedule a hearing with the Industrial Commission (IC) for contested or disputed issues. By law, BWC only has 7 days to refer the contested/disputed matter to the IC for hearing; therefore, it is critical that the MCO send this information timely.

3) Fast Response Program

According to R.C. 4123.511 and Rule 4123-3-36, under the Fast Response program, initial claim allowance of specific ICD-9 code conditions will be granted immediately and medical bills paid.

This program only includes State Fund-Private employers and Public Employer-Taxing District employers who have access to the Surplus Fund. Public Employer State Agency (PES) employers are excluded from the Fast Response pilot program.

BWC created a list of forty-nine (49) specific ICD-9 codes for this pilot project. Certain facts were considered in identifying these codes. For example:

- the number of claims for the medical condition;
- the percent of claims for the medical condition disputed;
- the percent of claims for the medical condition appealed;
- the percent of claims for the medical condition disallowed; and
- the average costs for the medical condition per claim.

Criteria for claims to be considered for Fast Response are:

- Claim filed for an initial claim allowance; and
- Claim contains *only one* ICD-9 code that is on the specific list identified by BWC.

Claims not meeting both of these criteria won't be considered for Fast Response processing. Instead, they will go through the normal claim review process. Consequently, if a claim request contains multiple ICD-9 codes and each of the codes are included on the list of approved ICD-9 codes, the claim won't qualify as a Fast Response claim.

BWC orders will be issued for Fast Response claims. Appeals on these claims are handled in the same manner as that of any other claim. If an employer contests the allowance of a claim involving any medical condition identified on the Fast Response list and the claim is disallowed, payment for the medical condition is charged to and paid

from the surplus fund. Refer to InfoStation's Medical Recovery policy for procedures to charge claim costs to the Surplus Fund.

The Fast Response Process

- Claim is identified by diagnosis/injury description as meeting Fast Response criteria.
- BWC claims specialist verifies all other compensability tests.
- If compensability tests are met, claim information is updated on V3.
- BWC order is issued allowing the claim and the claim status is updated to "Allowed".
- Medical bills can be paid immediately.
- If an appeal is filed to the BWC order, the claim status is updated to "Hearing" and is handled in the normal fashion.
- Should the IC overturn BWC's decision, all payments made on the claim are charged to the Surplus Fund.
- *****Refer to the Fast Response Workflow

The MCS will update a note in V3 under the Claims Category, titled "Fast Response Process". In the body of the text the MCS enters his/her first name and last initial.

Fast Response ICD-9 Codes
Numerical

ICD-9	Description
692.79	Solar Dermatitis NEC
872.01	Open Wound Auricle
872.02	Open Wound Auditory Canal
872.69	Open Wound Ear NEC
873.21	Open Wound Nasal Septum
873.22	Open Wound Nasal Cavity
873.44	Open Wound Jaw
873.64	Open Wound Tongue/Mouth Floor
873.65	Open Wound Palate
877.0	Open Wound Buttock
878.0	Open Wound Penis
878.4	Open Wound Vulva

ICD-9	Description
918.0	Superficial Injury Eyelids
921.3	Contusion of Eyeball
922.33	Contusion of Interscapular Region
930.0	Corneal Foreign Body
930.1	Foreign Body Injury Conjunctival Sac
930.2	Foreign Body in Lacrimal Punctum
940.1	Burn Periocular Area NEC
940.3	Acid Burn Cornea/Conjunctivitis
941.11	1st Degree Burn Ear
941.12	1st Degree Burn Eye
941.13	1st Degree Burn Lip
941.14	1st Degree Burn Chin

878.8	Open Wound Genital NEC
879.2	Open Wound Anterior Abdomen
879.4	Open Wound Lateral Abdomen
879.6	Open Wound Trunk NEC
880.01	Open Wound Scapula
880.02	Open Wound Axilla
881.00	Open Wound Forearm
881.02	Open Wound Wrist
882.0	Open Wound Hand
883.0	Open Wound Finger
890.0	Open Wound Hip/Thigh
913.6	Foreign Body Forearm
914.6	Foreign Body Hand

941.16	1st Degree Burn Scalp
942.10	1st Degree Burn Trunk NOS
942.12	1st Degree Burn Chest Wall
942.19	1st Degree Burn Trunk NEC
943.12	1st Degree Burn Elbow
943.14	1st Degree Burn Axilla
943.15	1st Degree Burn Shoulder
943.19	1st Degree Burn Arm-Multi
944.14	1st Degree Finger w/Thumb
944.15	1st Degree Burn Palm
945.11	1st Degree Burn Toe
945.19	1st Degree Burn Leg-Multi

3. Evaluation

Evaluation is the process of reviewing and considering the significance of each piece of information that is gathered. Evidence gathered during the investigation must be weighed so those reliable conclusions regarding claim compensability can be made.

a) CCT Determination

Determinations made by the CCT are based upon the following elements:

- The information is factual;
- Allegations are supported by objective documentation, such as diagnostic tests, police reports, etc.;
- Legal and/or medical opinions are supported by a rational explanation and are clearly documented;
- Identify if there are unresolved issues;
- Gather additional evidence as needed from the MCO. The CCT will work with the MCO to make the appropriate decision.

b) Diagnosis Determination Guidelines

BWC relies on MCOs to gather pertinent medical documentation from all treating providers to support the allowance determination. The claim allowance must be in ICD-9-CM format. To perform this function efficiently, BWC, MCOs and providers need to know the guidelines and criteria for diagnosis determination essential to substantiate diagnoses in claims. The medical documentation contained in the claim file is critical as evidence for the claims determination especially when this evidence is presented for a hearing.

The "Quick Reference" BWC Diagnosis Determination Guidelines were developed to provide criteria for diagnosis determination/coding decisions between BWC and the MCOs for the 30 most frequently utilized diagnosis/ICD-9 codes at BWC. The guidelines list the ICD-9 code with the diagnosis narrative description, subjective and objective exam findings, diagnostic tests and findings for diagnosis substantiation. The medical reports, documentation and diagnostic tests are submitted to the customer care team to assist in the claim determination. These guidelines are to be utilized as reference tools and are not intended to direct medical care or to be utilized in authorization of medical treatment. The "Quick Reference" BWC Diagnosis Determination Guidelines are included at the end of this chapter.

BWC's CCT will determine if the medical evidence obtained (or verified) with the MCO agrees with the subjective/objective exam findings for the specific diagnosis requested according to the Diagnosis Determination Guidelines. If the CCT obtains the appropriate medical evidence for a diagnosis (i.e., subjective/objective findings and/or diagnostic tests (if required) from the MCO/treating provider, the CCT will code the diagnosis according to:

- The ICD-9 code provided by the POR/treating provider;
- The diagnosis according to the narrative diagnosis description provided by the POR/treating provider. A narrative diagnosis is equivalent to an ICD-9 code. Consequently, for all injuries (other than minor injuries), if BWC obtains a narrative diagnosis from the MCO/treating provider, BWC is able to code this narrative description to the appropriate ICD-9 codes.

c) Claim Requirements

MCOs shall not assign ICD-9-CM codes. If the treating provider does not provide a diagnosis code and the MCO has attempted to obtain this information, then the narrative description of the injury as reported to the MCO will assist the CCT in completing their investigation**.**

Commonly Asked Questions

What is the significance of location?

- ICD-9-CM codes do not designate the side of body, i.e., right or left
- The designation of right, left or bilateral is required to fulfill our mandate to treat only conditions causally related and allowed conditions in the claim.
- The ICD-9-CM codes with potential for right or left designation have been identified and the location requirement is programmed in BWC's computer systems.
- The MCO identifies the location in EDI data element #26.

What is the significance of site?

- ICD-9-CM codes do not identify teeth (1-32), fingers (1-5), and/or part(s) of body, for example, disc number and location, i.e., L5-S1.
- Site is required when referencing fingers, toes, teeth and/or specific part(s) of body as again we would only be responsible for the medical care of

those digits, teeth and/or part(s) of body actually injured in the industrial accident.
- The ICD-9-CM codes identified as site required are programmed on BWC's computer systems.
- The MCO identifies the site in EDI data element #27.
- Always code to the highest degree of specificity possible, utilizing the maximum number of digits available (3-5) for the diagnosis coded.

Why is the specificity of ICD-9-CM so essential in the worker's compensation environment?

- Worker's compensation is not a whole health concept.
- The entire premise of worker's compensation is the focus on a specific injury to a specific body part(s) and therefore only the specific diagnosis(es) with medical evidence demonstrating a causal relationship.

Who is responsible for determining the diagnosis(es) and corresponding ICD-9-CM codes causally related to the industrial injury?

- The physician, either physician of record (POR), consulting physician or treating physician (e.g. emergency room physician).
- BWC's customer care team will assign an ICD-9 code upon verification of the narrative diagnosis.

What is causal relationship and why is it important?

- It is a medical determination.
- Based on review of the accident description and mechanism of injury, in the medical opinion of the reviewing physician, the evidence is sufficient to conclude that the injury resulted in the medical diagnosis(es).

What is the MCO's role in the investigation/determination/identification of diagnosis(es) in a BWC claim?

- Coordinate with the physician to ensure the proper identification of the diagnosis(es) and their corresponding ICD-9-CM codes.
- Ensure the necessary diagnostic work-up has been completed to support all alleged diagnosis(es).
- Identify physicians having problems with correct diagnosis identification or providing multiple unsubstantiated or redundant diagnosis(es) and utilize this information in your Quality Assurance Program to educate the physician on correcting these deficiencies.

What should the MCO do if there is a change and/or new diagnosis(es) felt to be causally related to the BWC claim?

- Work with the physician to ensure the proper identification of the diagnosis(es) and their corresponding ICD-9-CM codes.
- Ensure adequate documentation of causality for the changed and/or new diagnosis(es).

- MCO should report changes in diagnosis via 148 data element(s) #25, and if applicable, #26 and #27.

What is BWC's role in the determination/identification of the diagnosis(es) in a BWC claim?

- BWC, based on their review, may make subsequent requests of the MCO to clarify an issue or provide hard copy medical if the accident description, mechanism of injury, diagnostics or medical evidence does not prove a causal relationship and is not conclusive to allow a diagnosis(es).
- BWC maintains the ultimate responsibility for this medical/legal determination of the conditions to be allowed in the claim.

What should the MCO do if the POR is submitting multiple diagnosis(es) which are not substantiated?

- Communicate with the submitting physician in an attempt to "clean up" the data prior to submission to BWC.
- If discussion does not bring resolution, conduct Peer Review to effect behavior change.

What is the primary diagnosis and who is responsible for determination of this diagnosis?

- Identified for allowed conditions only.
- The "cost driver" of the claim.
- The diagnosis (only one) that determines the cost and duration of medical services/treatment and compensation.
- Dynamic in nature and can change throughout the life of the case as existing conditions are resolved and new conditions are identified.
- Determined by the physician of record (POR) with the MCO.
- A begin and end date field is required for the identified primary diagnosis.
- Primary diagnosis has no significance for reimbursement purposes, always bill with the diagnosis(es) treated.

How is the primary diagnosis(es) communicated to BWC?

- Initially, via the 148 transmission data element(s) #25, and if applicable, #26 and #27.

d) ICD-9 Description Modification

The Industrial Commission, as a hearing order, will occasionally allow an injury/condition with a different diagnosis description than the standard ICD-9 description. BWC legally has to change the standard ICD-9 description on the claim to match the published allowance in the order. This is a claim-level change, not an ICD-9 table change.

BWC only modifies the ICD-9 description based on Industrial Commission orders. BWC has the capability to modify the standard description to match

the published IC description. The modified description can be viewed on BWC's website or EDA.

This modified description should be used in medical management and authorization decisions.

4. Decision

Once all verbal and written documentation obtained during the investigation is thoroughly considered, a decision is made. Decisions are made impartially and objectively by applying the law within the spirit and intent in which it was written, and based on the evidence presented.

a) Claim Determinations

Once the decision is made, R.C. 4123.511 requires the CCT to issue a written legal notice, called a *BWC order*, to the injured worker and employer and their authorized representatives. The claim or medical condition allowance or denial will be sent via EDI to the MCO, who in turn, should update the provider. BWC's goal is to make claim determinations (ICD-9-CM assigned) within an average of 18 days of the initial notification of injury.

The Order may be issued once the investigation of the claim is completed and BWC has reached a decision.

b) Compensation and Benefits

BWC pays compensation and benefits based on injured worker eligibility. Bills can be submitted to the MCOs prior to the allowance of injured worker claims; however, payment will not be made until the claim is allowed.

c) Customer care team Time Requirements:

Initial and Subsequent Decisions	By law, 28 days are allowed to investigate and issue a decision. BWC's goal is to make claim determinations within an average of 18 days of the initial notification of injury.
Additional Compensation	Should be completed within specified time requirements as outlined in BWC policies and procedures. However, it is critical to pay the injured worker timely and in most cases medical documentation from the MCO is crucial in making the appropriate determination for payment.

C. OUTCOME MANAGEMENT PHASE

Outcome Management focuses on bringing the claim to a desired result after it is allowed by investigating, monitoring and managing the extent of injury and extent of disability issues in the claim.

1. Investigation

Investigations enable the CCT to issue fair, accurate and timely decisions. The depth of investigation will be different with each claim, depending upon the type of the injury and issues involved in the claims.

2. Extent of Injury

Extent of Injury defines the severity of the injury or occupational disease to a specific body part(s). It may involve a new condition(s) or worsening of the allowed condition(s). The CCT considers:

- Is the injury supported by objective medical evidence?
- Is there evidence that the condition is a result of the accident?

a) Additional Allowance (See MCO Portal for updates)

The additional allowance process begins when an MCO receives a Physician's Request for Authorization of Medical Service or Recommendation for Additional Conditions for Injury or Occupational Disease (C-9) recommending allowance of an additional condition.

Proactive pursuit of additional allowances provides the physician an opportunity to deliver services to an injured worker earlier resulting in quality and appropriate care and potential for earlier return to work.

BWC will not consider proactively allowing conditions that are psychological, congenital, degenerative in nature, or a result of natural deterioration. Conditions of a traumatic nature will be considered for an additional allowance.

MCOs are responsible for providing input to BWC on whether the medical evidence in the claim file supports the existence of the additional condition requested The MCO shall contact the provider who recommended the additional allowance(s) to obtain the following information when it is not on file:

- Supporting medical documentation, including clinical examination and diagnostic test findings;
- Current treatment plan;
- ICD-9 diagnosis code for requested diagnosis (include specific diagnosis description- e.g., 722.10 Lumbar HNP, L4-L5 and identify if primary ICD-9)
- ICD-9 location (right, left, or bilateral) when applicable;
- ICD-9 site (digits, teeth, or body part) when applicable;

BWC will either allow the condition or notify the injured worker or his/her legal representative to request the condition in writing. BWC will inform the MCO of the final decision and the MCO will notify the provider who recommended the additional allowance of the action BWC is taking regarding the proactive allowance.

The MCO may assist an employer in understanding the medical information in the claim file if requested by the employer or BWC.

MCOs and providers are not considered parties to the claim and therefore may not appeal the BWC decision.

BWC will not pursue an additional allowance and will notify the injured worker or his/her legal representative to request the condition in writing when any of the following occur:

- A party to the claim, including the injured worker/employer representatives, disagrees with the allowance of the condition(s);
- A condition that is psychological, congenital, degenerative in nature, or a result of natural deterioration is recommended;
- The medical documentation/evidence does not clearly establish causality or does not support allowance of the condition;
- A BWC physician review or exam is needed; or
- A response is not received from the IW regarding agreement/disagreement to allowance of the recommended condition.

The MCO may assist the provider to identify situations in which they believe an additional allowance may be appropriate and advise the provider of the process that is required to request the additional allowance. The MCO may not instruct the provider to file a motion (C86) for an additional condition because the provider is not a party to the claim and is not permitted to file a motion.

b) Legal and Medical Issues on a C-86 motion

When both legal and medical issues are submitted on a C-86 motion, BWC will address the legal issue and refer the medical issue to the MCO. The CCT will forward the C-86 motion and the Notice of Referral letter to the MCO. The MCO must date stamp the C-86 upon receipt.

The MCO will issue a decision to the C-86 motion in writing to the parties in the claim, detailing its plan of action, within 3 business days after receipt.

- ✓ If the MCO is unable to make a decision within 3 business days due to the need for additional information, the MCO has 5 business days from the date additional information is received to make a subsequent decision.
  (**NOTE: BWC-certified physicians are required to provide the MCO with any requested documentation within 5 business days.)**
- ✓ If the MCO is unable to make a decision within 3 business days due to the need for a medical review, the medical review must take place and a decision granted within the 5 business day period.

If the C-86 motion is a request for **reactivation** or **authorization of treatment**, the MCO will follow the procedures detailed in the Provider Treatment Plan Approval Guidelines found in chapter 3 of this manual. Requests for reactivation must be closely coordinated with the CSS, following the reactivation guidelines summarized later in this chapter, for a thorough investigation to insure treatment/services requested are related to allowed conditions in the claim. This determination should be made prior to treatment approval, especially for inactive claims.

If the C-86 motion is a request to **terminate treatment**, the MCO will support its decision by submitting a plan to resolve the medical issues in the claim. The plan must include, at a minimum:

- Diagnosis (including designation of primary diagnosis);
- Prognosis;
- Expected Outcomes (including anticipated RTW);
- Approved POR or treating physician's treatment plan (C-9).

If the medical issue that is the basis of the C-86 motion filed with BWC is a treatment decision by the MCO and the party (and their representative) filing the C-86 motion (1) received notice of the treatment decision and (2) failed to appeal the treatment decision through the ADR process within 14 days after receiving notice of the decision, the MCO must accept and process the untimely filed appeal through ADR and may not deny the C-86 motion on the grounds that the party failed to timely appeal the treatment decision.

If the party (or their representative) did not receive notice of the decision, the MCO must proceed with addressing the issue. This will preserve the rights of parties (and their reps) who fail to receive notice similar to that provided by R.C. 4123.522 for BWC and IC orders.

Any party to the claim may appeal the MCO decision and initiate Alternative Dispute Resolution within 14 days of receipt of written notice of an MCO determination.

3. Extent of Disability

Extent of Disability defines the period of time the injured worker is unable to work as a result of the injury/disease and is entitled to receive compensation. The CCT considers:

- Is the period of disability supported by objective medical evidence?
- Is the disability related to the allowed conditions in the case?

During the Outcome Management Phase, the CCT monitors the progress of activities by primarily responding to:

- Action plan target dates;
- New treatment plans from the MCO;
- Requests for actions from the parties in the claim (such as additional allowances and/or compensation).

As in the *Initial Decision Phase*, the CCT has certain time requirements and will most likely need medical documentation to support the team's decisions and meet these mandated times. Therefore, it is critical that the MCO submit all requested documentation in a timely manner.

d. CLAIM OUTCOME PHASE

Claim Outcome focuses on the claim status once all issues have been resolved. The Claim Outcome Phase may involve closure of the whole claim or resolution of the outstanding issues. The Claim Outcome Phase includes the following resolutions, which apply to the whole claim or issues in the claim.

1. Whole Claim

a) Expirations of the Statute of Limitations

Claims with a date of injury from 12/11/67 to 8/24/2006:

- Medical Only claims = 6 years from date of injury or last medical paid
- Lost Time Claims = 10 years from last Medical or Indemnity paid in claim or six years from the last medical payment, if no compensation is paid.

Claims with date of injury **on or after** 8/25/2006:

- Lost time and medical claims = 5 years from the date of injury or last **payment** in claim

b) Denial of Compensability (all appeals exhausted)

The claim has been denied in its entirety; therefore, neither medical benefits nor compensation will be paid.

c) Full Settlement of the Claim (R.C. 4123.65)

Full settlement of the claim occurs when BWC, with the agreement of the employer and injured worker, pays the injured worker a sum of money. A claim may be settled for either medical benefits or indemnity, or both medical benefits and indemnity. Per R.C. 4123.65, settlement can be initiated **only** by the parties to the claim, which are the injured worker/injured worker representative, employer/employer representative, or BWC.

Each MCO should appoint a Settlement Coordinator for their organization. The role of the MCO Settlement Coordinator is to be the main point of contact at the MCO regarding settlement issues. The Medical Billing and Adjustment department has also assigned staff to work with specific MCOs to resolve billing issues.

1.) MCO Notification of Lump Sum Settlement Application

The MCO will be notified of applications and statuses via the portal. The MCO will send via notes confirming or providing the status of the bill resolution process.

a) Provider Notification of Lump Sum Settlement

Once a C240 application is input into Application Tracker, Medical Bill and Adjustments (MB&A) will send an initial settlement notification letter to providers who have billed BWC within the 6 months. The letter requests that all unpaid medical bills be immediately submitted to the MCO LSS Coordinator for payment. Additionally the letter directs the provider to contact the MCO to resolve outstanding billing issues for bills previously submitted. Providers, such as vocational rehab providers, will not be notified if there is no billing history.

b) MCO bill history review: (Bill Resolution)

Upon notification by email - The MCO will review for outstanding (not yet submitted) bills based on the C-9s approved and medical notes in the file. MCOs are also provided a billing history report from MBA to aid in

researching previously submitted bills. This report will show all bill activity in the BWC system both paid and unpaid (paid at $0.00). The BWC billing history report details all providers that have billed in the claim within past 6 months. **To resolve bills, the MCO must pay special attention to reviewing the $0.00 paid bills.**

- If there are billing issues that are easily correctable by the provider, the MCO must notify provider immediately by phone of the issue, have them correct, and resubmit ASAP.

- If the bill was denied for lack of prior authorization, MCO will expedite the medical review/authorization process. **MCOs must review the services incorporating *Miller* criteria. Denials for prior authorization alone are merely administrative. If the services are medically appropriate and would not deny for any other reason than prior authorization, they should be paid.** For settlements, there must be specific medical reasons for an MCO to deny.

- "red flags"
    - Alpha claims with no bills.
    - Claims with a majority of bills approved at 0.00
    - Claims previously assigned to MCOs that are now decertified, have merged with another MCO, or changed as a result of open enrollment (new MCO may be unaware of earlier bills)
    - Claims with bills paid at unusually low amounts (provider billed $5,000.00 but approved amount is $15.00)
    - Claims with bills approved at 0.00 with no edit or EOB
    - Claims with bills in unresolved (U) status
    - Claims with bills denied for lack of prior auth or medical (check *claim file for the medical to reprocess bill)*

The MCO must encourage providers to submit any unpaid bills immediately. Providers must also be advised that dates of service on or after the effective date of settlement (the date the approval order is issued) will not be paid. Providers can determine settlement status via the BWC website.

The MCO will document in MCO notes the bill resolution update and progress.

- Pre-settlement adjustments should be sent to the LSSPA mailbox as these are flagged for priority handling

Settlement and retroactive services:

Retro C-9s:

If the MCO receives a **retro C-9** during bill resolution and dates of services are prior to the effective date:

- Adhere to the request for medical service approval guidelines as outlined in Chapter 3 of this manual for retro C-9s;
- Notify the LSS CSS of any retro C-9s for services with a value of over $1,000.00 or any retro C-9s that may impact the value of the settlement.

Bills requiring prior authorization:

If MCO receives a bill(s) for retroactive dates of services during bill resolution:

- Notify the LSS CSS of any bills totaling over $1,000, or any other bills that may impact the value of the settlement.
- Address medical necessity of treatment request and process the bill(s) accordingly with medical already on file. It is not always necessary to ask for a C-9.
- Adhere to the request for medical service approval guidelines as outlined in Chapter 3 of this manual;
- Adhere to billing guidelines in Chapter 8 of this manual;

The MCO shall make every attempt to process all bills during the pre-settlement period.

a) MCO Staffing with Provider on C-9s

Upon receipt of the email notification from BWC, the MCO will notify the POR/treating physician to ensure he/she:

- Understands an application for settlement was filed.
- Understands that any previously authorized C-9s into the future should be reconsidered and adjusted to the settlement timeframe;
- Understands that all services and bills for dates of services after the effective date of settlement are the responsibility of the injured worker.
- Reviews medical repository for medical documents and submit if there is a gap in the information.
- Continues to provide previously authorized treatment until the effective settlement date and understands additional treatment will not be authorized unless one of the following occurs:
  - The settlement is dismissed;
  - A party withdraws from the settlement;
  - The settlement is taking longer to process than expected.

In settlements, "resolved" does not mean the end of the billing cycle. It means that all bills that are medically appropriate are indeed paid to provider.

*** By signing the C240 the employer and injured worker agree that all pending applications or unresolved issues, including issues currently appealed in the Industrial Commission will be suspended. Pending ADR disputes and permanent total disability applications are not suspended by the filing of the C240. ADR proceedings may continue through final settlement and beyond, if necessary, to resolve outstanding ADR disputes.

2.) Once settlement is approved by BWC

- BWC will send the approval letter to the parties;
- BWC will notify the MCO weekly of settlement application status changes via MCO portal.
- An outbound 148 will be sent to the MCO using one of the following settled pending status:
  - PM (settled for medical-only)
  - PI (settled for indemnity only)
  - PB (settled for medical and indemnity)

The 30-day waiting period will begin and no treatment requests (C-9s) will be approved and no medical payments will be made during this time.

When the MCO receives the 148 with the settled pending status they will:

- Immediately advise all providers actively treating (approved C-9s) by phone or fax that C-9s have expired and bills for dates of service on or after the effective settlement date will be the responsibility of the injured worker.

- Advise providers that the MCO is no longer responsible for ongoing case management of the claim.

- Advise providers that medical bills will be held during this time and payable bills with dates of service prior to effective settlement date will be processed at the end of the 30 days waiting period. Bills received and held during the 30 days holding period should be submitted to BWC no later than 7 business days from the end of the 30 days waiting period.

3.) Settlement Withdrawn or Disapproved - during the 30 day waiting period, any party can withdraw from the settlement in writing.

- **If the settlement is withdrawn or disapproved:**
  - BWC will send a disapproval letter to the parties;
  - BWC will notify the MCO weekly of settlement application status changes via the MCO portal;
  - The MCO will notify providers that the settlement has been disapproved or withdrawn and, if appropriate, that treatment can be reinstated.

4.) Settlement Final

The settlement is considered binding and final if written withdrawal is not received during the 30 day waiting period. BWC will notify the MCO weekly of settlement application status changes via the MCO portal. Additionally, BWC will send an outbound 148 to the MCO with one of the following claim statuses:

- SM (settled for medical only)
- SI (settled for indemnity only)
- ST (settled for medical and indemnity)

***Providers can determine settlement status via the BWC website**

5.) Requests For Bill Payment After a Settlement

After a claim is settled, parties to the claim and providers may contact BWC requesting resolution of unresolved medical bills. They should be advised to submit unpaid medical bills for services rendered prior to the settlement date to their assigned MCO for consideration.

a) MCO receives RetroC-9 - after final settlement

1.) If the date of service is **prior to** effective settlement date, adhere to the request for medical service approval guidelines as outlined in Chapter 3 of this manual.

2.) If the date of service is **on or after** the effective settlement date, the MCO should notify the provider that the claim is now settled and that C-9 is dismissed.

b.) MCO receives bills – after final settlement

If the bill is payable as determined by medical management criteria, and the date of service is prior to the effective settlement date, the MCO will process the bill via normal 837 so the billing data can populate Cambridge. No override required for settled status.

- **If the bill is not payable** based on medical management criteria or the date of service is on or after the effective settlement date, the MCO will notify the provider with the appropriate EOB describing the reason for denial.

Motions requesting bill payment after settlement will be referred to the MCO if the bill is payable according to BWC bill payment criteria. The motion will be referred to the MCO using the MCO Referral letter. The Referral letter will include the following statement "Claim is settled and the bills should be considered for payment based on the policy effective July 12, 1999. Bills have been reviewed and are payable according to BWC bill payment criteria."

6.) Bill Resolution for Court Ordered Settlements

The BWC Legal Division will be notified via e-mail by the Attorney General's Office of a court settlement. The BWC Legal Division will forward the e-mail to the LSS e-mail box for the service office responsible for processing the settlement

BWC LSS staff will at the same time add a **note to V3** indicating receipt of the court settlement notification **and the settlement date** as indicated in the AG e-mail. ***This date is the effective settlement date for C-9s and bills.***

Once the LSS CSS has received the court settlement notification, the claim status will be updated to medical-settled (SM). The MCO will receive an outbound 148 indicating this status. In the court settlement context, medical-settled status does not necessarily indicate that medical only is settled in the claim. Most court settlements include settlement of medical and indemnity. Claim notes describing the AG e-mail notification should be reviewed to confirm the effective settlement date.

The MCO will continue to resolve bills up to and beyond the effective settlement date as long as the bill is within 2 years from date of service and the date of service is before the effective settlement date. Bills for dates of services after the effective settlement date will be denied due to court settlement and will be the responsibility of the injured worker.

Claims outcome

a) Return to work guidelines utilized by MCOs shall be the Official Disability Guidelines. The MCO shall develop, document and maintain a plan for RTW services for all lost time (LT) claims that include RTW expectations and outcomes. MCO case notes must demonstrate coordination between the IW, provider and employer in the creation of the RTW plan.

b) The MCO shall assess its RTW plan for injured workers who have exceeded the 50th percentile on the Measurement of Disability (MoD) Days Absent benchmarks for claims with one or more days lost, plus 30 days. If the MCO has not already communicated its plan to BWC's CCT, the MCO shall communicate its plan to the CCT and partner on resolution of the claim.

c) **30 day RTW assessments**

The Disability Management Coordinator will review **all claims** in which the injured worker has not returned to work thirty (30) days beyond the 50th percentile of the MoD Days Absent benchmarks. Return to work barriers will be identified in these claims and if the barriers appear to be valid, BWC will set a diary for review at an appropriate future date. If the barriers are not valid, BWC and the MCO will come to mutual agreement about a future course of action. If the MCO does not follow through with these steps, the MCO will then be asked to implement "Thirty (30) Day Assessment

Recommendations. These recommendations are submitted to the MCO via e-mail from the Service Office Manager. If BWC and the MCO still cannot arrive at a mutual solution, the MCO may appeal the 30-Day Assessment Recommendation within five (5) working days to the Administrative Designee E-mail box.

d) **Return to Work Data** – see Chapter 9.

e) **Partial Settlement**

Partial Settlement of a claim means BWC, with the agreement of the employer and injured worker, agrees to pay the injured worker a sum of money. This payment will forever resolve all past, present or future issues or liabilities for a particular part of the claim (medical or indemnity) or a particular condition(s) in the claim.

f) **Supportive Medical Care**

Supportive Medical Care indicates that the injured worker has a successful return to work and/or has reached MMI or has settled the indemnity portion of the claim and is only receiving supportive/maintenance type medical treatment.

g) **Resolution of Appeals**

Once the BWC Order is issued, if either party (injured worker or the employer) disagree with the decision they have 14 days to file an appeal with the Industrial Commission (IC). The IC will schedule a hearing with a district hearing officer. The district hearing officer will issue a written legal notice (IC Order) of the decision. If either party disagrees with the decision, they may file an appeal with the IC within 14 days. The IC will schedule a hearing with a staff hearing officer. Medical bills will not be paid while the issue of allowance is under appeal with the IC. However, compensation benefits can be paid after the district hearing, if the claim is allowed and compensation is owed. The staff hearing officer will issue an IC Order with the decision. If either party disagrees with the decision, they may file an appeal with the IC within 14 days. The IC will refer the matter to the Commission to decide if a hearing will be scheduled.

If the Commission decides to hear the appeal, it will issue a written notice to the parties in the claim of time and place of the hearing. The Commission will issue an IC Order after the hearing with its decision. If the Commission decides not to hear the appeal, it will issue an IC Order to that effect. If either party disagrees with the decision, they may file an appeal with the Court of Common Pleas within 60 days. Extent of disability issues cannot be appealed to the Court of Common Pleas.

h) **Maximum Medical Improvement (MMI)**

MMI occurs when an individual's medical condition has stabilized to the point that no fundamental functional or physiological change can be expected despite continuing medical or rehabilitative intervention. However, an IW may still need and be entitled to ongoing medical care once MMI has been reached. Temporary total compensation benefits may be terminated when an IW has reached MMI. The MCO will notify the CCT when there is reason to believe a claim has reached MMI. MMI must be documented by a licensed physician; however, the MCO should not be soliciting MMI statements from the physician of record (POR). The MCO will forward medical documentation in support

of this conclusion either from the POR or an independent medical examiner to the CCT immediately. The injured worker may be eligible for other types of partial or permanent compensation.

D. INACTIVE CLAIM/REACTIVATING A CLAIM

1. MCO 148 Refresh and Claim Reactivation Requests

Periodically, there are questions regarding when to request a 148 refresh or for a claim to be reactivated and who to contact at BWC. A 148 Refresh is a process which is used to re-send claim data to an MCO via a 148 EDI transaction, in instances where the data was or should have been previously sent but was not received. Claim Reactivation is a process used to activate an inactive claim for an MCO and results in an outbound 148. The following information will help clarify the appropriateness of requesting a 148 refresh versus a claim reactivation request.

a. Requesting a 148 Refresh

1) 148 refresh requests are appropriate if :

- The claim is active and;
- The claim is assigned to the MCO and;
- Claim data was previously sent to the MCO but not received or;
- The MCO is switching system vendors.

2) Procedures

- MCO must assign one person as the individual responsible for requesting refreshes. This person will also be responsible for investigating the reason why the refresh is needed.
- Requests must first go to the MCO Business Unit Representatives so that BWC understands who, what, when and WHY the request is being made. This may prompt the need for further consultations with the MCO.
- Requests that involve multiple claims need to be submitted in an electronic format. Preferably an email attachment as a text file or a diskette as a spreadsheet. BWC will conduct audits of the claims submitted and may reject the entire refresh request if the MCO did not properly research the claims (e.g., a claim is listed for which that MCO is not the proper MCO).
- Requests must include a legitimate reason as to why a refresh is needed. "Don't have the claim on our system" is not legitimate. An example of a legitimate reason would be "the claim is not on our system due to power outage for several hours causing system not to update."
- All refreshes will go through the regular production mechanism EDI.
- BWC may treat these requests as a public records request and may assess a charge.

b. Requesting a Claim Reactivation

1) Requests to Activate a Claim

When a claim is inactive, requests for benefits and/or services may be submitted to BWC or the Managed Care Organization (MCO). The MCO will

receive requests for medical services and/or medical bill payments and BWC will receive requests for allowance of additional conditions and/or compensation.

A request to "activate" a claim, absent a specific request for benefits and/or services, such as allowance of an additional condition, compensation payments, or medical service is not a valid request. BWC will not consider activating a claim unless there is a specific request for additional allowance, compensation payment, medical/pharmacy bill payment, treatment or diagnostic testing.

If BWC or the MCO receives a verbal request to reactivate the claim and the request is not supported by medical documentation with a specific request for benefits and/or medical services, the request cannot be addressed. BWC and the MCO will document the circumstances regarding this situation in notes. No additional action is required.

It is not necessary that the request specifically include the verbiage 'claim reactivation'. Any request for treatment, additional allowance or compensation in an inactive claim will be construed as a request to reactivate the claim. If no treatment is pending, BWC needs to address the additional allowance or compensation request in its normal manner

However, if a telephone call is received from a treating physician or IW requesting payment for a service that has already been provided, that is enough to start the claim reactivation process. BWC and the MCO will document the circumstances regarding this situation in notes. The MCO will begin the initial review to determine if current medical is on file and prepare its clinical findings before referring the request to BWC.

Treatment for the purpose of this policy includes office visits, emergency room visits and/or diagnostics. However, in order to be a valid request it must be accompanied by current medical documentation dated not more than 60 days prior to the date of the request (or such documentation must be provided to the MCO upon request via C-9A or equivalent). Requests for prior authorization for office visits, emergency room visits and/or diagnostics without current medical documentation (e.g. office visit note, ER report, etc.) are not valid requests for claim reactivation.

If BWC receives an invalid request on a C-86 motion, the MCS/CSS will follow up with the requesting party to find out what specific benefits and/or services the party is seeking. If an invalid request is submitted on a motion and BWC cannot determine the specific benefits and/or service the party is seeking, the motion will be dismissed by letter. The request may be dismissed only after BWC has attempted to gather additional information and documented the attempt in V3 Notes.

If the MCO receives an invalid request on a C-9, the MCO will follow up with the requesting party to find out what specific benefits and/or services the party is seeking. If the MCO cannot determine the specific benefits and/or services the party is seeking, the C-9 will be addressed by the MCO according to their current procedures. The MCO will document action taken in notes.

The parties to the claim may submit a new claim reactivation request clearly outlining the specific benefits and/or services requested with supporting documentation for consideration later.

MCO C-9 dismissals, which will be faxed to the service office after MCO processing, must attach the C-9A used to communicate with the provider. These two documents will be imaged into the system by BWC and will be part of the claim file.

Once BWC and the MCO receive supporting documentation for the verbal request, C-86 Motion or C-9 they may proceed with the claim reactivation review process. BWC and the MCO will work in partnership using the most efficient and effective communication method to discuss any outstanding issues in an attempt to reach consensus and to try to resolve all conflicts prior to issuing a BWC Order.

2) Inactive Indicator

The Medical Claims Specialist (MCS) or the Claims Service Specialist (CSS) may manually activate a claim as determined appropriate. When a claim becomes active, it will be presented to the Micro Insurance Reserving Analysis (MIRA) in the weekly processing. If the claim does not have a reserve, it will stay unreserved until something occurs in the claim that causes a reserve to be set (i.e., a compensation payment
The "Inactive" indicator will display on the Version 3 status tool bar. Both the active/inactive histories will display in the Active/Inactive History window. MCOs can view the current inactive date via electronic data access (EDA). The MCO will need to contact BWC for the active/inactive claim history, if necessary. Additionally, the current active/inactive indicator and date will be sent to the MCOs and the pharmacy benefits manager (PBM) via electronic data interchange (EDI).

Note: If an MCO needs to have the claim data transferred to their system, the MCS/CSS will change a field in the Maintenance, Injured Worker Window, click OK and then change it back the same day (e.g. the injured worker's middle initial). This will create an outbound 148 transaction and the claim information is sent to the assigned MCO.

3) Request for Medical Service Received on a C-9 or Similar Form

When the MCO receives a request for medical services via a C-9 or similar form and the claim is inactive, the MCO will pend the request, if necessary, obtain medical documentation to support the request, notify the provider, fax

the C-9 or similar form to the service office fax queue. The MCO will email in accordance with the Sensitive Data Policy the assigned MCS/CSS and copy the Team Leader when referring the issue to BWC.

A C-9\medical service request that is referred to BWC for a reactivation review will be faxed to the appropriate service office imaging fax line. In addition, the MCO will send an email to the assigned MCS/CSS and copy the Team Leader with the standard title: "Request for Reactivation Review". The email will include the claim number, medical service issue, and the name of the provider requesting the treatment\diagnostic testing. BWC will reply to the MCO email within three business days advising the MCO of the receipt of the claim reactivation request and that processing has begun. The Team Leader should be copied on the reply to the MCO.

The MCS/CSS will investigate the issues prompting the medical service request to determine if the requested benefits and/or services are causally related to the original claim allowance. BWC and the MCO will work in partnership using the most efficient and effective communication method to discuss any outstanding issues in an attempt to reach consensus and to try to resolve all conflicts prior to issuing a BWC Miscellaneous Order. All efforts by BWC and the MCO will be documented in notes.

The MCO will ensure the medical service request is supported by medical documentation prior to sending the request to BWC. Additionally, the MCO will work in partnership and discuss issues with BWC and the MCO will update their notes with the clinical findings and their recommendation to either allow or deny the request.

The MCO note will be titled, "Claim Reactivation Clinical Findings". BWC is aware that some MCOs do not have the capability to enter actual note titles or that they do not have enough character spacing for a long title. If an MCO does not have the capability to enter a note title, the MCO can enter the "Claim Reactivation Clinical Findings" in the first line of their note. If an MCO does not have enough character spacing, the note title can be condensed to "Claim Reactivation" or some abbreviation that would reflect that it pertains to claim reactivation.

When responding to the provider, the MCO will select the C-9 checkbox entitled "Claim Inactive."

There is lag time for the MCO notes batching process, which incorporates 33 plus servers to merge into our batching system to display in V3. Please expect delays from 2-4 days to receive the MCO notes into V3.

MCO Clinical Findings must be entered into MCO system notes and must be in the claim prior to BWC issuing a BWC Order. If the clinical findings are sent by the MCO via email in accordance with the Sensitive Data Policy,

BWC will copy and paste the clinical findings for claim reactivation into V3 notes. The V3 note will be titled, "MCO Claim Reactivation Clinical Findings." This is necessary so that there is no delay in processing the claim reactivation request. BWC will respond to the MCO and explain that in accordance with policy, future clinical findings must be entered in the MCO system notes. The Team Leader should be copied on the email response to the MCO.

If the verbal request, C-9 or C86 motion request is received and there is no medical evidence or the medical evidence is dated more than sixty days prior to the date of the request, the MCO will dismiss the request and will not forward it to BWC.

The MCO must ensure the verbal request, C-9 or C86 motion request is accompanied by medical evidence dated not more than sixty days prior to the date of the request. The MCO may dismiss the request if:

- There is no supporting medical evidence or;
- The medical evidence is dated more than sixty days prior to the date of the request.

The request may be dismissed only after the MCO has made an attempt to gather supporting medical evidence. The MCO will document the attempt to obtain supporting medical documentation in their notes. When dismissing the C-9\medical service request due to no supporting medical or if the medical evidence is dated more than sixty days prior to the date of the request, the MCO will select the C-9 checkbox entitled "Dismissed." Additionally, the MCO will include the following statement on the C-9 to the provider: "Request for medical service authorization is dismissed as there is no supporting medical documentation or the medical evidence is dated more than sixty days prior to the date of the request. This decision is not appealable. "

The MCO will have an additional three business days from the receipt of the requested medical documentation to review the medical documentation, work in partnership and discuss issue with BWC, update their notes with their clinical findings and refer the request to BWC; or dismiss the request. The MCO clinical findings must include the opinion of the MCO physician or Medical Director if one was provided. Additionally, the MCO Medical Director may recommend a BWC independent medical exam, which must also be updated in the MCO notes.

If medical documentation is received to consider along with the request, the MCO will refer to BWC with its clinical findings. The MCO's clinical findings note must include at a minimum the following information:

- The date of C-9(s), (Physician's Request for Authorization and/or Recommendation of Additional Conditions)
- A definitive description of the treatment/service
- The frequency and duration

- The beginning and ending dates that cover the medical treatment request, this will help determine if there are duplicate requests
- The body part being treated, including ICD codes
- An indication if the treatment has been previously rendered or not
- MCO recommendation to allow or deny
- MCO recommendation if a BWC IME is needed
- Medical evidence relied upon to support recommendation
- An indication of which prong of Miller the treatment does not meet if recommending a denial
- MCO Medical Director opinion and recommendations (when applicable)
- Any other information the MCO would like to relay to BWC

The MCO shall obtain any missing information listed above from the treating provider and will update the information in the MCO notes. If the MCO is unable to obtain beginning and ending dates from the provider, the MCO may use the date that the MCO recommendation was made as the beginning date, and then assign the ending date. It is not necessary to obtain dates for a one-time consult, diagnostic studies or surgery.

Additionally, the MCO must indicate the medical evidence that was relied upon to reach their recommendation, e.g., progress notes, consultations, diagnostic reports, etc.

The MCO will ensure the medical service request meets the *Miller* criteria and any other medical treatment authorization protocols currently in place when recommending the approval of the medical service. When recommending a treatment denial, the MCO notes must indicate which prong of Miller is not met.

The MCO may make a recommendation to allow or deny the request; however, prior to making their recommendation the MCO may indicate a physician review or IME is necessary. The MCO will collaborate with BWC to have the review/IME happen and once the review/report is on file, BWC will collaborate with the MCO and the MCO will document their clinical findings in their MCO notes.

The Medical Service Specialist (MSS) and other Customer Care Team (CCT) resources, which include the MCO, may be included when staffing inactive claim issues as necessary.

BWC will refer claim reactivation and treatment issues for a physician review or independent medical exam (IME) within the 28-day timeframe. Additionally, BWC may refer the issue for an IME when recommended by the MCO Medical Director.

The appropriate Claim Reactivation Order Language will be used when issuing the decision. The MCS/CSS will update the V3 Notes with the details

of the investigation findings. BWC will notify the MCO through email or phone of the decision issued by BWC Order and inform the MCO of the appeal period expiration date. The Team Leader will be copied on the response. BWC will notify the MCO if an appeal is filed to the BWC Order.

Upon receipt of the final BWC/IC decision to allow the claim reactivation, the MCS/CSS will manually activate the claim after all appeal periods have expired, unless the parties to the claim submit waivers. The MCS/CSS will use the current date, as the reactivation date unless the IC specifies a different date. BWC will enter a V3 note that identifies why the claim was manually activated. BWC will send an email in accordance with the Sensitive Data Policy to the MCO with the final outcome of the claim reactivation process. The MCO will notify the physician of record or treating provider of the final decision.

The MCO will pend any additional C-9\medical service requests received during the reactivation review and BWC\IC appeal process. The MCO will inform the CSS by email in accordance with the Sensitive Data Policy if the new request is for a different condition than the request that triggered the reactivation review. The following statement will be included on the C-9: "C-9 is pended as a claim reactivation review is currently in process based on a prior treatment request."

Medical service requests for treatment previously denied by BWC/IC Order will be handled the same as duplicate requests. The response to the provider must indicate the date of the IC or BWC Order that previously denied the treatment issue. However, if there are new and changed circumstances, the request must be referred to BWC for a reactivation review.

If necessary, the claim reactivation process may take up to 44 days to complete. The MCOs will have a maximum of 16 business days to respond to the treatment request and refer the claim reactivation issue to BWC. MCOs will not automatically use 16 days in every case, but will take the appropriate action at any point during the 16 days.
This includes:

- Three business days to review the treatment request, work in partnership and discuss issues with BWC, update the MCO notes with the clinical findings, refer the issue to BWC, and respond to the provider if medical documentation is not needed; or pend the request to obtain medical documentation from the provider. The MCO may also request claim data from BWC, if necessary.
- Ten business days for the provider to submit additional information to the MCO if needed;
- Three business days from the receipt of requested medical documentation to review the request, work in partnership and discuss issues with BWC, update MCO notes with the clinical findings, respond to the provider by letter, and refer the issue to BWC or

dismiss the request if the medical documentation is not submitted.

BWC will forward medical service requests to the MCO when received on aC-86 Motion . The MCS/CSS will refer the issue to the MCO using Right Fax and will enter a V3 note to document the request was Right Faxed to the MCO. The MCS/CSS will wait for the MCO to send an email in accordance with the Sensitive Data Policy requesting Claim Reactivation review before beginning due process and investigation.

If the MCO is not able to obtain medical documentation to support the medical services request, the MCO will dismiss the C86 motion. The MCO is dismissing the medical treatment request that happens to be filed on a C-86 motion. The fact that the treatment request is on a C-86 Motion is irrelevant, as the treatment issue itself takes precedence over the form used to make the request and the MCO has authority to issue decisions on treatment requests no matter what form is used to make the request.

However, when the C-86 for medical services is sent to BWC and is supported by medical evidence; BWC will immediately begin the investigation. BWC will still Right Fax the request along with medical evidence and send an email in accordance with the Sensitive Data Policy notification to the MCO so they are aware of the claim reactivation request. This gives the MCO the opportunity to review the request and provide their clinical findings in the notes. BWC will begin due process and the investigation while the MCO is formulating their clinical findings. BWC and the MCO will work in partnership using the most efficient and effective communication method to discuss any outstanding issues in an attempt to reach consensus and to try to resolve all conflicts. BWC will not issue an order until the MCO clinical findings are documented in the MCO notes.

The email sent by BWC in accordance with the Sensitive Data Policy will provide notification to the MCO that the motion was faxed to them along with the medical evidence. Additionally, the email will contain the following information:

- Claim number
- Injured worker's name
- Date of motion
- Date of attached medical documentation

4) Requests for claim reactivation and additional allowance

Oftentimes, there is a claim reactivation request filed with BWC requesting specific treatment and an additional allowance. The claim reactivation request must be addressed whether or not BWC is able to address the additional condition(s). When this type of situation occurs, the MCS/CSS must review the additional condition to determine if it may be allowed. The request for

treatment must still be addressed even if the additional condition is not allowed. This process still involves BWC and the MCO working together using the most efficient and effective communication method to discuss any outstanding issues in an attempt to reach consensus and to resolve all conflicts prior to issuing a BWC Miscellaneous Order and the MCO must still provide their Clinical Findings on the treatment request to BWC when the request for claim reactivation is sent to BWC

- If treatment depends on the allowance of the additional condition and after the investigation, the MCS/CSS determines that the treatment and additional allowance may be allowed in the claim. The MCS/CSS will need to issue an Additional Allowance, Wages and Compensation Order. The MCS/CSS will us "add text" in the order to address the treatment issue.

- If treatment depends on the allowance of the additional condition and after the investigation, the MCS/CSS determines that some of the treatment and additional condition may be allowed and some treatment needs to be denied, the MCS/CSS will issue an Additional Allowance, Wages and Compensation Order. The MCS/CSS will use "add text" in the order to address the treatment issues, indicating what is being allowed and denied on the order.

- If treatment depends on the allowance of the additional condition and after the investigation by the MCS/CSS, it is determined that the additional condition may be allowed, but the treatment requested should be denied, the MCS/CSS must issue the Additional Allowance, Wages and Compensation Order. The MCS/CSS will use "add text" in the order to address the treatment issue citing what treatment specifically is being disallowed on the order.

- If treatment depends on the allowance of the additional condition and, after the investigation by the MCS/CSS, it is determined that the additional condition will not be allowed, the MCS/CSS must still allow or deny the treatment request by issuing a BWC Miscellaneous Order. The MCS/CSS may hold the treatment request for a limited time if they are able to hold for the C86 motion for the additional condition to come in during the 28-day processing.

- In some instances after issuing a BWC Miscellaneous Order, the Motion may be received by BWC. The MCS/CSS must determine if a decision may be made within the appeal period and verify that no appeal has been filed by the Employer or Injured Worker to the BWC Order. If no appeal has been filed, proceed with the review of the additional condition, which may require a physician review. If the recommendation is to deny the additional condition, the MCS/CSS must issue a Notice of Referral to the Industrial Commission. If the

recommendation is to allow the additional condition(s), the MCS/CSS will need to verify that BWC is still within the appeal period and that no appeal has been filed to the BWC Order. If no appeal has been filed and BWC is still within the appeal period, the MCS/CSS will vacate the BWC Miscellaneous Order issued for treatment only and issue the Additional Allowance, Wages, and Compensation Order allowing the additional allowance and in the add text space, addressing the treatment requested.

5) C-92, C-92A, C-240 and IC-2 Applications

Application for Determination of Percentage of Permanent Partial Disability or Increase of Permanent Partial Disability (C-92 and C-92A) applications

If the claim is inactive, the tracking of a C-92 or a C-92A application will not systematically reactivate the claim. The claim will remain inactive until the CSS is ready to draft and publish a tentative order. Issuing a tentative order

- Dismissal; the claim will not be manually reactivated.
- Grant State Fund; claim will be manually reactivated if awarding 1% or more. The claim will not be manually reactivated if BWC is granting 0%.
- Increase State Fund; claim will be manually reactivated if awarding 1% or more. The claim will not be manually reactivated if BWC is granting 0%.
- Reinstatement; claim will not be manually reactivated.
- Suspensions; claim will not be manually reactivated.

If a C-92 or C-92A is filed in the claim right after the filing of claim reactivation request, the processing of the claim reactivation request should **not** stop. The claim reactivation issue should be resolved prior to the completed processing of the C-92 or C-92A application.

If a C-92 or C-92A is filed in the claim before the filing of a claim reactivation request and the CSS will activate the claim for payment of a %PP award prior to an order being issued for the claim reactivation request, the CSS **must** contact the MCO by phone or email to refer the claim reactivation issue back to the MCO to address. No BWC Order regarding the claim reactivation request will be issued after the claim is activated for some other reason. No correspondence is necessary to be sent, but a V3 note should be entered into the claim.

If a BWC Order has been issued to deny claim reactivation and treatment and the claim is subsequently reactivated for payment of a C-92 award the BWC order regarding treatment stands and appeals to the treatment issue are referred to the IC.

Settlement Agreement and Application for Approval of Settlement Agreement (C-240) applications

If the claim is inactive, the tracking of a C-240 application will not systematically reactivate the claim.

The CSS will manually reactivate the claim when it is determined that a valid lump sum settlement application has been filed with BWC. This will be necessary to have all the outstanding medical bills paid in the claim prior to a successful settlement of the claim.

If the claim is NOT settled and the C240 application is dismissed, withdrawn or disallowed; the settlement team will reset the claim to inactive status, unless medical bills have been paid in the claim, then the claim will remain in active status. 24

Permanent Total Disability (IC-2) applications

If a claim reactivation request is received and in process and an IC-2 application is filed in the claim the claim will systematically reactivate. The MCS/CSS must notify the MCO **immediately** through email in accordance with the Sensitive Data Policy or phone.

- if there has been no BWC Order issued, processing must stop on BWC's side and the C-9 (treatment request) must be referred back to the MCO to address under their normal procedures and appeals to the MCO decision will follow the normal ADR process. BWC will not issue an order in this situation. The action completed must be documented in V3 notes.

- if there has been a BWC, Order issued, the order stands and appeals are processed through the IC. If no appeal is filed the decision issued in the BWC Order is final.

6) Issuing a Claim Reactivation Decision

BWC will issue a Miscellaneous Order to allow or deny the claim reactivation (causality and treatment) issue based on the information available once the investigation, review and discussion with the MCO is completed. The BWC Order will be the result of collaborative efforts on the part of BWC and the MCO to ensure that the requested benefits and/or services are appropriate.

BWC will determine or draw its conclusion in favor of the injured worker if there is no contrary evidence or evidence that reveals any unrelated intervening incidents or conditions R.C. 4123.95

A physician review or IME will be required if BWC and MCO is recommending denial and must be done prior to issuing the BWC Order to support the denial decision. All other reactivation requests will be sent for physician review or IME as the facts of the claim warrant based on an informal or formal staffing with the MCO. Additionally, BWC may refer the claims reactivation issue for an IME when recommended by the MCO Medical Director. The recommendation should be documented in the MCO notes.

The BWC Order must identify the specific treatment information driving the claim reactivation. This includes the date of the C-9 and the specific treatment being requested. This helps to avoid confusion due to duplicate or multiple C-9s/medical service requests. In addition, factual and medical evidence relied upon to make the decision must be cited in the Order. MCO notes and clinical findings are not considered medical evidence. However, the MCO notes and clinical findings must indicate the reports and/or tests relied upon to reach the decision.

BWC must indicate the following information in the order to describe the treatment issue driving the claim reactivation:

- The date of C-9(s)
- A definitive description of the treatment/service (Do not include CPT codes in the BWC Order)
- The frequency and duration if appropriate
- The beginning and ending dates if appropriate

BWC will notify the MCO through email in accordance with the Sensitive Data Policy or phone of the decision issued by BWC Order and inform the MCO of the appeal period expiration date. The Team Leader will be copied on the response. BWC will notify the MCO if an appeal is filed to the BWC Order.

BWC will notify the MCO by email in accordance with the Sensitive Data Policy of the final BWC/IC decision, whether allowed or denied, after all appeal periods have expired. The MCS/CSS should **not** update the claim to active until all appeals have been exhausted, unless waivers to the appeal period have been received. The MCO may view the BWC/IC Order on Ohiobwc.com. The MCO will notify the provider of record and/or treating provider by letter of the final BWC/IC decision. The MCO will have 30 days from the BWC email in accordance with the Sensitive Data Policy to notify the provider if the treatment has already been rendered. If treatment has not been rendered, the MCO will have three days to notify the provider of the BWC/IC decision.

7) C-9/Medical Service Requests Already Rendered

C-9/medical service requests that have already been rendered are referred to as retro C-9s.

Retro C-9s that are referred to BWC and indicate a request for both retro and future treatment will be addressed by BWC in their entirety.

Retro C-9s with multiple dates of service that are both before and after the inactive date will be addressed by BWC in their entirety.

The MCO will refer to BWC those retro C-9/medical service requests where the date of service (DOS) is after the current inactive date. BWC will issue an order in this instance.

The MCO will not refer retro C-9/medical service requests to BWC for a reactivation review and BWC Order when the date(s) of service (DOS) is prior to the current inactive date. The MCO will process these C-9/medical service requests according to the procedures outlined in the Request for Medical Services Approval Guidelines found in Chapter 3 of the MCO Policy Reference Guide. These decisions may be appealed through the ADR process since the MCO is making the decision on the issue. The MCO may contact the assigned MCS/CSS to obtain the active/inactive history.

The BWC billing system, Cambridge, will compare the bill's date of service (DOS) to the Active/Inactive last paid date of service (A/I LPDOS) to determine payment. Therefore, if the MCO allows the retro C-9, they may not need to contact the assigned MCS/CSS to request the claim be manually reactivated for bills with a DOS prior to the last paid date of service, (LPDOS).

The MCO will not refer retro C-9/medical service requests to BWC when the DOS is prior to the current inactive date. Authorized services provided prior to the claim inactive date will be paid without the claim being reactivated. However, the claim will become active if the date of service being paid is within the last 24 months. See Billing Workflow & Job Aid for Inactive Claims to determine when BWC needs to be contacted to manually activate a claim.

The following example demonstrates when retro C-9/medical service requests should not be referred to BWC.
Claim is inactive
Date of service: 1-16-2010
Inactive Date: 5-22-2010
Result: DOS is prior to the inactive date. Reactivation review is not required. Claim will become active if the DOS is within 24 months from the current date.

The following example demonstrates when retro C-9/medical service requests should be referred to BWC.
Claim is inactive
Date of service: 6-16- 2010
Inactive Date: 5-22--2010
Result: DOS is after the inactive date, so a reactivation review is required.

In some instances when a retroactive date of service is prior to the inactive date, but more than 24 months after Active/Inactive last paid date of service (A/I LPDOS), the MCO will need to request the claim be manually reactivated if they are approving the treatment. In some instances, there may not be an A/I LPDOS listed in V3 and in this instance, the MCS/CSS will need to manually activate the claim if the MCO is approving treatment. If the claim is not manually activated the bills will continue to deny. BWC will not issue an order in this instance, but will manually activate the claim within three days of the MCO request. The CSS/MCS will use the date of the MCO's email as the date to manually reactivate the claim. The MCO email will be titled "Manually activate claim due to retro C-9." MCO will also enter a note regarding the retro C-9. (See Billing Workflow & Job Aid for Inactive Claims.)

The following example demonstrates when a DOS is prior to the inactive date but more than 24 months after A/I LPDOS:
A/I LPDOS: 01-5-2007
Inactive Date: 11-15-2009 (claim remained active due to compensation payment)
Requested retro DOS: 10-01-2009
Result: DOS is before the Inactive Date, but after the A/I LPDOS + 24 months date; therefore, the MCO will request BWC manually activate claim due to retro C-9 through email in accordance with the Sensitive Data Policy. The MCO email should copy the team leader. If the MCO does not request manual activation, bills will continue to deny.

8) Prosthetic and Durable Medical Equipment

Pursuant to Rule 4123-3-15 (B)(1)(e), the MCO will not refer reactivation review requests to BWC relating to prosthetic devices or certain durable medical equipment (DME) contained in this policy.

Below is a list of reactivation (prosthetic/DME) requests that are the MCO's responsibility:

- Prosthetics
- Orthotics
- Durable Medical Equipment (DME) categories as outlined in The 2005 Medical Management Institute's Healthcare Common Procedure Coding System (HCPCS), Level II Codes:
    - Canes, codes E0100-E0105

    - Crutches, codes E0110-E0118
    - Walkers, codes E0130-E0149
    - Decubitis Care Equipment (e.g. Heel or elbow protector), codes E0180-E0199
    - Heat/Cold Application (e.g. electric heat pad), codes E0200-E0239
    - Safety Equipment, codes E0700-E0701
    - Restraints, E0710
    - Other Orthopedic devices (e.g. adjustable elbow extension), codes E1800-E1902
- Vision, hearing, and dental supplies (e.g. eyeglasses, hearing aids, dentures)
- Medical supplies (e.g. hearing aid battery)

***Please note:** not all equipment in the above categories are covered by BWC, please refer to Billing and Reimbursement Manual.

For inactive claims, the MCO will work in partnership via phone and e-mail to discuss and staff the issues of the request with BWC. If the MCO allows the request, they will send the assigned MCS/CSS an email in accordance with the Sensitive Data Policy with the rationale supporting the MCO approval of the medical service/supply and request a manual reactivation of the claim to facilitate automated bill payment. The MCO's email will be titled "Manually activate claim." The MCO will also enter a note. BWC will not issue an order in this instance, but will document V3 notes stating why they are reactivating the claim. The MCS/CSS will manually activate the claim within three business days of the MCO request. The MCS/CSS will use the date of the MCO's email as the date to manually reactivate the claim. These decisions may be appealed through the ADR process since the MCO is making the decision on these issues.

When a C-9 request is received and is requesting DME in addition to other treatment and the claim is inactive, the MCO will refer the matter to BWC and the request for DME and treatment will be addressed by BWC in their entirety.

Any DME not on the list above will follow the active/inactive policy and be referred to the assigned MCS/CSS via email in accordance with the Sensitive Data Policy for investigation and BWC Order on inactive claims. The MCO will ensure the medical service request is supported by medical documentation prior to sending the request to BWC. Additionally, the MCO will work in partnership and discuss issues with BWC and the MCO will update their notes with the clinical findings and their recommendation to either allow or deny the request.

The MCS/CSS will provide due process, conduct an investigation, review the MCO clinical findings in the MCO notes, work in partnership and discuss any

issues or conflicts with the MCO, refer the issue for a physician review or IME and issue a BWC Miscellaneous Order addressing the medical service/treatment request and claim reactivation. These decisions may not be appealed through the ADR process since BWC is making the decision on these issues.

Question and Answer
Q. If the MCO receives a bill for DME under $250.00 and it is just for "maintenance" on an orthotic or prosthetic that will periodically be billed, would an actual reactivation review need to be completed? For example in this particular case, the IW required a new "cup" screwed into the knee orthotic/prosthetic and this will most likely need to be replaced again in approximately two years (just an estimate).
A. Most likely, for the situation described, a reactivation review may not be necessary; however, BWC and the MCO should staff the claim (formally or informally) to determine the appropriate course of action for these types of situations (i.e. one time, periodic equipment replacement/maintenance). It may not be appropriate to perform a reactivation review. All decisions should be documented in V3 notes.

9) Reactivation Review for Payment of a previously denied Medical Bill

A provider or any party to the claim may contact the MCO and request a reactivation review for medical bills that were denied because the date of service was after the current inactive date. The request for a reactivation review is not required to be in writing but will be documented in the notes.

Parties may not understand to request a reactivation review when inquiring about a previously denied bill. Therefore, the MCO may construe an inquiry the same as a request for a reactivation review. Additionally, the MCO should gather medical documentation to support the request if it is not on file. To document the request for a reactivation review, the MCO will update their notes

Requests for payment of a previously denied bill due to claim inactivity will be considered similar to C-9/medical service requests. The MCO will process the following medical bill payment requests and will not refer them to BWC:

- Services for Prosthetics
- DME listed in this policy
- Medical bills with a date of service prior to the inactive date and A/I LPDOS. See Billing Workflow & Job Aid for Inactive Claims.

Additionally, the MCO will apply its current clinical editing and medical management criteria to the request. For example, if the service requires prior authorization, the MCO will follow the policy outlined in the MCO Policy Reference Guide.

All other requests will be referred to the assigned MCS/CSS through email. The MCS/CSS will provide due process, conduct an investigation, review the

MCO clinical findings in the MCO notes, work in partnership and discuss any issues or conflicts with the MCO, refer the issue for a physician review or IME and issue a BWC Order. As a part of the investigation, the MCS/CSS will contact the parties and may contact the provider to gather additional medical information or to clarify information.

The MCO will ensure the medical service request is supported by medical documentation prior to sending the request to BWC. If the request is not medically supported or the medical evidence is dated more than sixty days prior to the date of the service, the MCO will dismiss the request and will not forward it to BWC. Additionally, the MCO will update the MCO notes with the clinical findings and their recommendation to either allow or deny the request.

The MCO note will be titled, "Claim Reactivation Clinical Findings". BWC is aware that some MCOs do not have the capability to enter actual note title or that they do not have enough character spacing for a long title. If an MCO does not have the capability to enter a note title, the MCO can enter the "Claim Reactivation Clinical Findings" in the first line of their note. If an MCO does not have enough character spacing, the note title can be condensed to "Claim Reactivation" or some abbreviation that would reflect that it pertains to claim reactivation.

There is lag time for the MCO notes batching process, which incorporates 33 plus servers to merge into our batching system to display in V3. Please expect delays from 2-4 days to receive the MCO notes into V3.

If either BWC or the IC allows the treatment request, the MCO may pay/adjust the bill that was originally denied. The bill payment will serve as notification to the provider. Otherwise, if the request is denied by the BWC or the IC, the MCO will respond in writing to the provider. Since the medical service has already been rendered, the MCO will have 30 days from the BWC email to communicate the bill payment decision to the provider.

10) Vocational Rehabilitation and Claim Reactivation

Rule 4123-18-03(B)(6) states that a referral for vocational rehabilitation on an inactive claim is processed in accordance with Rule 4123-3-15(A).

When the Managed Care Organization (MCO) receives a request for vocational rehabilitation on an inactive claim, the MCO will refer to Chapter 4 Vocational Rehabilitation Referral Process and Initial Feasibility Review, Claim Reactivation Referrals for further instructions.

The MCO will not issue correspondence on the referral for vocational rehabilitation when the claim is inactive.

11) Multiple C-9/Medical Service Requests

Same as or Similar Treatment Requests

If the MCO receives a new C-9/medical service request and the procedure requested appears to be the same as or similar to a previous treatment request which is pending before the Bureau or Industrial Commission, the MCO will defer consideration of the new request until the previous treatment request is resolved. The MCO will notify the provider that the C-9/medical service request will not be addressed until the reactivation review has been completed and the appeal period has expired.

The MCO will pend subsequent C-9/medical service requests received during the reactivation review and BWC/IC appeal process. The following statement will be included on any additional C-9/medical service requests received during the reactivation review and BWC/IC appeal process: "C-9 is pended as a claim reactivation review is currently in process based on a prior treatment request dated <Enter Date of request>."

If additional C-9 requests are received after the MCO sends their initial request for claim reactivation review along with their clinical findings to BWC, the MCO will staff with the MCS/CSS to determine if the new C-9 can be included in the investigation. Including the new C-9 in the process would prevent double physician reviews/IME in the event a review or IME is needed. IF the MCS/CSS is too far into the investigation process, the new C-9 will be held by the MCO until the first determination is complete.

"Denying," claim reactivation procedures

Once the appeal period has been exhausted (14 days + 4 days for mailing) and the final decision is to deny the claim reactivation and treatment request, the MCO will process the subsequent C-9/medical service requests that are the same as or similar by a written letter dismissing the request. In the written letter dismissing the request, the MCO will indicate that they do not have jurisdiction to address the C-9/medical service request as claim reactivation was previously denied by the BWC/IC. The MCO will make absolutely certain that there is no appeal language in the letter. The response to the provider must include the date of the BWC/IC Order that previously denied claim reactivation, the date of the C-9, and treatment issue requested.

The letter and C-9 requests will be faxed to the service office fax line and be a part of the claim file in imaged documents.

If the MCO receives a new C-9/medical service request, after claim reactivation has been denied and the appeal period has expired, and the procedure requested on the C-9 appears to be the same as or similar to a previous treatment request, the MCO will process the subsequent C-9/medical service requests by a written letter dismissing the request. In the written letter dismissing the request, the MCO will indicate that they do not have jurisdiction to address the C-9/medical service request as claim reactivation

was previously denied by the BWC/IC. The MCO will make absolutely certain that there is no appeal language in the letter. The response to the provider must include the date of the BWC/IC Order that previously denied claim reactivation, the date of the C-9, and treatment issue requested.

"Authorized," claim reactivation procedures
Once the appeal period has been exhausted (14 days + 4 days for mailing) and the final decision is to allow the claim reactivation and treatment request, the MCO will process the subsequent C-9/medical service request utilizing their current procedures. Refer to the MCO Policy Reference Guide.

Multiple procedures requested
If the MCO receives a new C-9/medical service request and there are multiple procedures requested, the MCO will review and determine whether or not the procedures have been previously addressed.

If a C-9/medical service request contains both a same as or similar procedure that has already been addressed by BWC/IC Order and one or more other procedures that was not addressed by BWC/IC order, the MCO will forward the C-9 to BWC to address the specific procedures not previously addressed. For the procedures that have been previously addressed by BWC/IC Order, the MCO will notify the provider of the outcome on those specific procedures. The MCO will make sure that notification to the provider does not contain appeal language. This includes the C-9s that are requesting retro and current treatment, DME and previously denied medical bill payments.

Example
The MCO receives a C-9/medical service request that is asking for the following:

Physical Therapy for L shoulder 3 times a week for 4 weeks
MRI L shoulder
MRI Cervical Region

Per MCO review, the claim has an IC DHO Order dated 11/28/2010 denying claim reactivation and additional physical therapy in this claim. No other decision regarding treatment is on file. The MCO realizes it has an 'old' issue already address on the new C-9/medical service request, but there is also a 'new' issue requested on the C-9/medical service asking for an MRI L shoulder & cervical region which has not been previously addressed.

The MCO will ensure the medical service request is supported by current medical documentation prior to sending the request to BWC. Additionally, the MCO will work in partnership and discuss issues with BWC and the MCO will update their notes with the clinical findings and their recommendation to either allow or deny the request.

The MCO will notify the provider that the C-9/medical service is pended and the request was referred to BWC for a claim reactivation review.

Refer to Request for Medical Service Received on a C-9 or Similar Form Section of this Chapter for additional processing guidelines.

Substantial Change
If the MCO receives a C-9/medical service request and the MCO reviews the updated medical documentation and determines there is substantial change which impacts treatment and may impact the previous claim reactivation decision, the request **must** be referred to BWC for a reactivation review.

The MCO will ensure the medical service request is supported by medical documentation prior to sending the request to BWC. Additionally, the MCO will work in partnership and discuss issues with BWC and the MCO will update their notes with the clinical findings and their recommendation to either allow or deny the request.

A C-9\medical service request that is referred to BWC for a reactivation review will be faxed to the appropriate service office imaging fax line. In addition, the MCO will send an email in accordance with the Sensitive Data Policy to the assigned MCS/CSS and copy the Team Leader with the standard title: "Request for Reactivation Review". The email will include the claim number, medical service issue, and the name of the provider requesting the treatment\diagnostic testing. . BWC will reply to the MCO email in accordance with the Sensitive Data Policy within three business days advising the receipt of the claim reactivation request and that processing has begun. The Team Leader should be copied on the reply to the MCO.

12) Bankrupt Self-Insured

When BWC initially takes responsibility for bankrupt self-insured employer's files, BWC audits and updates V3 for those claim that are identified by the self-insured employer as being active. The other claims, identified as inactive, are housed in MAFIL until something is received on the claim to indicate activity.

Before the claim reactivation process can occur on bankrupt self-insured claims, the file will need to be physically audited by the assigned CSS and V3 updated. This is necessary to verify the allowed conditions in the claim are documented in V3 and to determine whether the claim is truly inactive.

When a C-9 or request for payment of medical service is received by the MCO, the MCO must identify if the claim is a bankrupt self-insured claim. If the claim is identified as a bankrupt self-insured claim, the MCO should contact the assigned CSS to notify them of the request received.

The assigned CSS will request the file and upon receipt will audit the

employer's records and update V3. The CSS will have six (6) business days to receive the file, complete the audit, update V3, and notify the MCO of the following information:

- The audit of the file has been completed,
- The allowed conditions in the claim, and
- The active/inactive status of the claim.

At this time, the CSS will also inform the MCO that they may proceed with the claim reactivation process if the claim is truly inactive. See Request for Medical Service Received on a C-9 or Similar Form Section of this Chapter.

The CSS may begin the claim reactivation process after the claim has been audited, however, the CSS will not issue a BWC Miscellaneous Order until the Clinical Findings have been received by the MCO.

13) Inactive Claim Criteria

Team Leaders may reset a claim to inactive in V3 if the claim was activated inappropriately or if the claim was activated to update data that will not result in a payment. However, once a payment is made for medical or compensation, the team leader cannot reset the claim back to inactive unless he/she requests the V3 Customer Team to modify the indemnity date or medical date. Before the V3 Customer Team will modify the medical or indemnity date, the MCS/CSS must have proof that the bill has been adjusted. This must be documented in V3 notes. In the case of indemnity, the benefit plan must be adjusted, any outstanding warrants should be pulled, and the status changed to void credit if possible.

Claims will systematically change from active to inactive over the weekend because of one of the following scenarios:

- A claim is settled for medical and indemnity and there is no open IC-2 application;
- A claim is in a disallowed or dismissed status and there is no open IC-2 application:
- A claim is allowed, with no settlement or only partially settled, and there are no:
  - Payments made within 24 months of the claim filing date and/or;
  - Medical bill payments made within 24 months of the last date of service;
  - Indemnity payments made within 24 months of last payment;
  - Manual activations within the last 24 months;
  - Open IC-2 applications.

14) Active Claim Criteria

Version 3 will allow a claim to remain active based on any one of the

following criteria:

- Indemnity payments are made within the last 24 months or within 24 months of claim filing;
- Medical payments are made within 24 months from last date of service or within 24 months of claim filing;
- Claim status is either new claim, alleged , hearing, or appeal;
- There is a IC-2 application in an open status in the V3 Application Tracker;
- The claim is manually activated within the last 24 months;
- The claim is a covered SI (non-bankrupt).

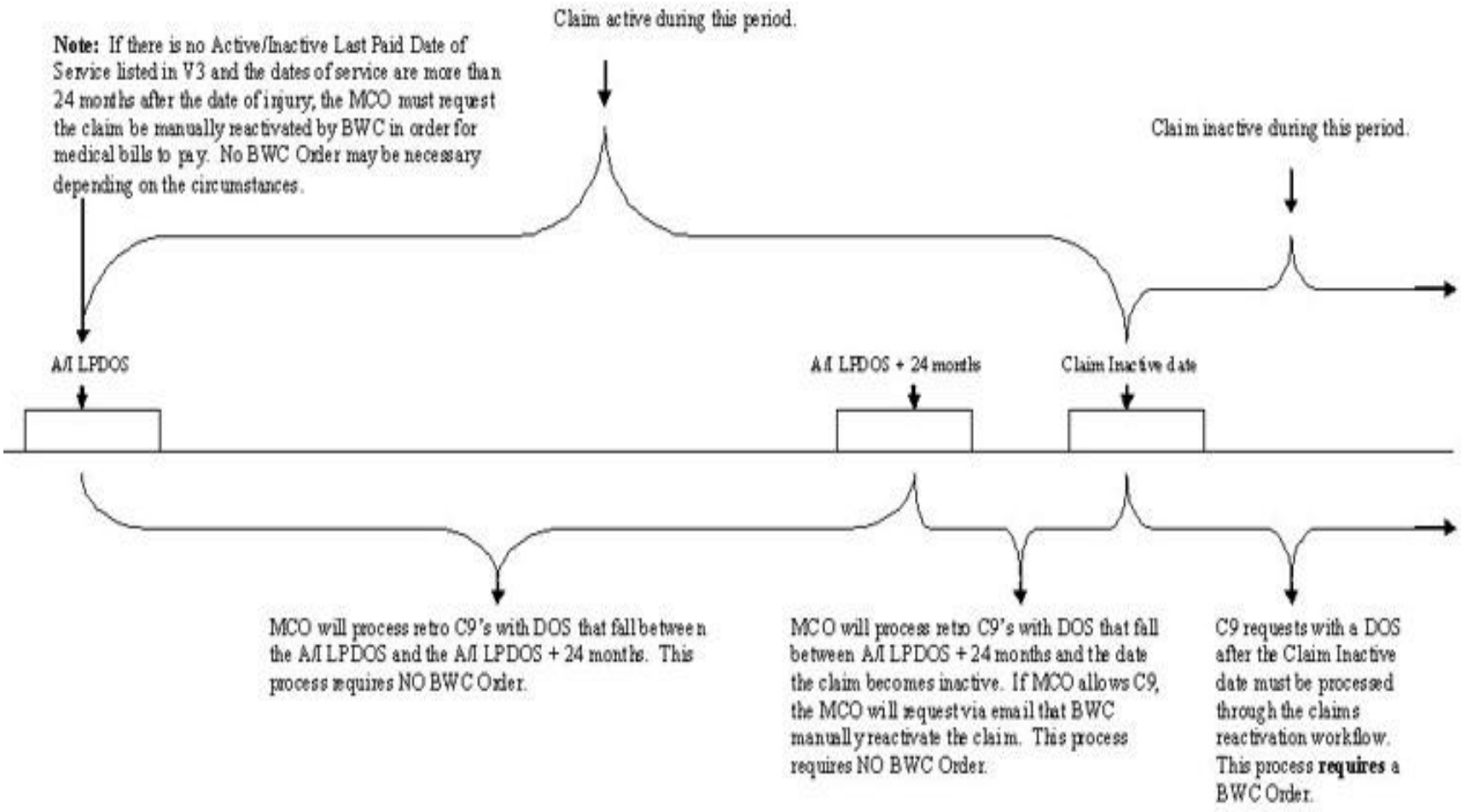
A claim will be systematically changed from inactive to active if one of the following occurs:

- The claim is manually activated;
- An IC-2 application is entered into the Version 3 Application Tracker.
- An ICD is placed in allowed or DHO Hearing status.

15) EOB 265

When an MCO receives a bill for a service that does not require prior authorization (e.g. office visit, emergency room visit) and the claim is inactive, the MCO will follow its normal review process, attach all applicable EOBs and submit the bill to BWC for denial with EOB 265: Payment is denied because the claim is inactive because there has been no medical treatment in the claim in the last 24 months and the billed services may be unrelated to this claim. Additional information can be found in the Reactivation Guidelines in the Billing and Reimbursement Manual.

Billing Workflow & Job Aid for Inactive Claims



A/I LPDOS = the active/inactive last paid date of service.

A/I LPDOS + 24 months = 24 months after the active/inactive last paid date of service.

Claim inactive date = 24 months from the last date of claim activity.

Updated 10-12-2010

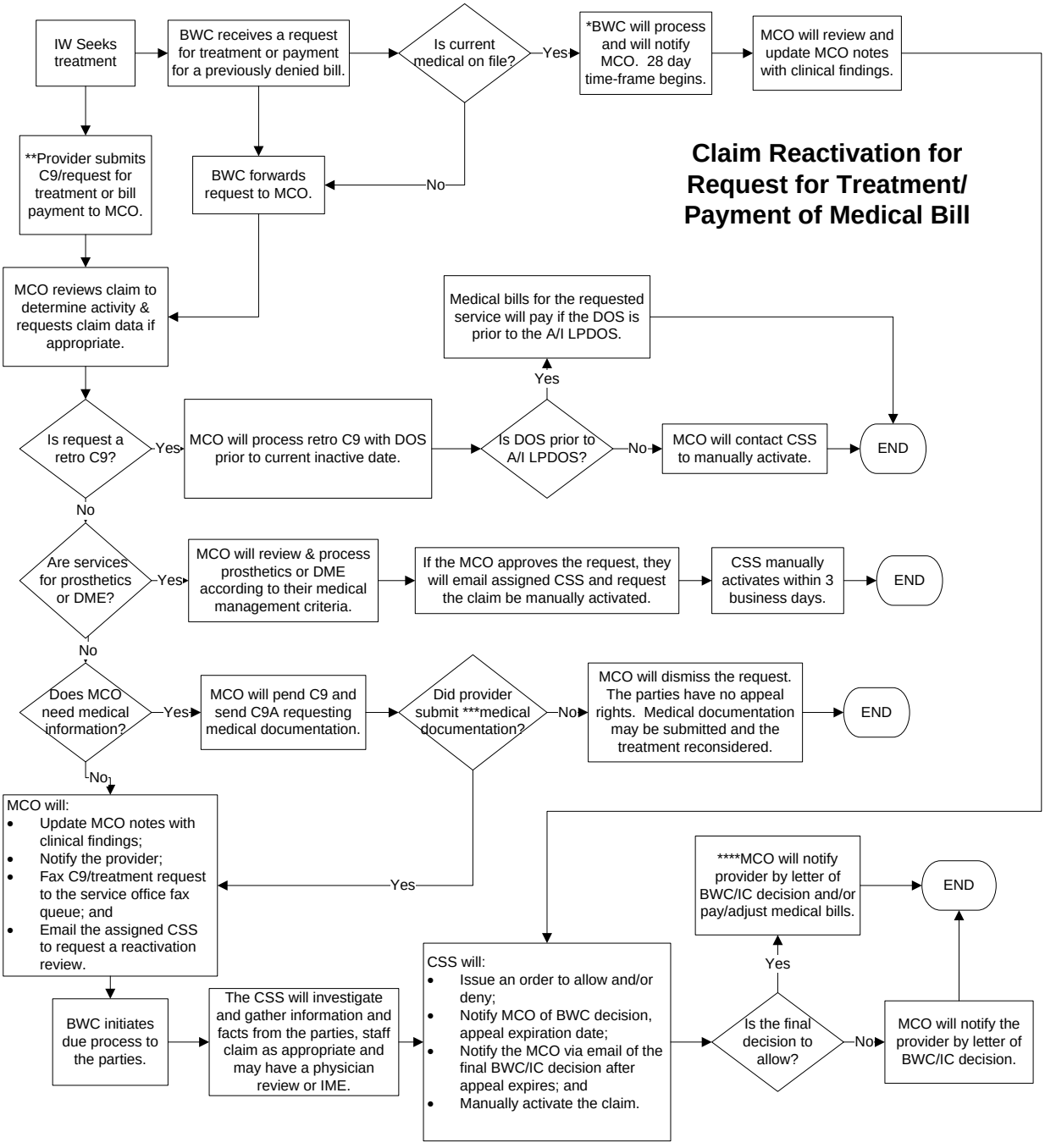
Claim Reactivation Check List - MCO

Claim Number: IW's Name: NCM:

Please note that this check list does not cover situations that include retro C-9s, prosthetics and durable medical equipment, additional conditions requested, and requests for medical bill payments. Therefore, this check list may not be used in those instances.

Question	Check List ✓
Was C-9 received requesting treatment/medical request on an inactive claim? • Claim is inactive. • Current medical to support request. • If no medical, MCO requested medical from POR on C-9A • If no current medical received after 10 days, C-9 should be dismissed.	
Was the POR notified that the claim is inactive, pending BWC Reactivation Review?	
Was an email sent to BWC CSS/MCS titled "Request for Reactivation Review?" Was the BWC Team Leader copied?	
Was C-9 and current supporting medical faxed to the Service Office Repository?	
Were clinical findings entered in MCO notes and sent to BWC?	
Did "Clinical Findings" note include the following? • The date of C-9(s) • Definitive description of service/treatment • The frequency and duration of service/treatment • Beginning and ending dates of treatment/service request • Body part being treated, including ICD code • Indication if treatment was previously rendered or not • Recommendation to allow or deny • Recommendation if BWC IME is needed • Medical evidence relied upon to support recommendation • Indication of which prong of Miller the treatment does not meet, if recommending denial • MCO Medical Director opinion and recommendations (if applicable) • Additional information MCO wants to share with BWC	
Was email response received from MCS/CSS that "request for reactivation review" was received?	
Did MCO staff and partner with BWC on outstanding issues on claim reactivation?	
Was C-9 held for 28 days for BWC Reactivation Review?	
Was email received from BWC informing MCO of the decision issued by BWC Miscellaneous Order and the appeal period expiration date?	
If no email from BWC has been received and it is greater than 28 days since the request for reactivation review was received, was a follow-up email/phone call sent to the MCS/CSS (copy team leader on emails) requesting an update on the status?	
Was the C-9 request held for the appeal period?	
Was email received from BWC advising if an appeal to the BWC Order was received? If no appeal filed, was email received from BWC advising the final decision on the claim reactivation process?	
If no email from BWC and it is after the appeal period expiration date, was a follow-up email/phone sent to MCS/CSS (copy team leader on emails) on the final outcome of the claim reactivation status?	
If appeal was filed, did MCO receive an email from BWC on the final outcome on the claim reactivation issue (after DHO, SHO, & IC hearings are completed)?	
MCO received final outcome on the claim reactivation issue. Did MCO notify provider of the final outcome on the claim reactivation and treatment request?	

Updated 10-12-2010



*BWC may process if the DOS is after the current inactive date and/or request is for a DME not listed in the policy.
**Any party to the claim can request a reactivation review for the payment of a previously denied medical bill, including the provider.
***Medical documentation should be dated not more than sixty days prior to the date of the treatment/request to be current.
****MCO may deny medical bill for clinical editing even though the claim is activated.
Updated October 12, 2010

Claim Reactivation Quick Reference Guide

ISSUE	MCO	BWC	PBM	IC
Treatment Request	Within 3 days, send email to CSS to request review once medical received. Fax C-9 to BWC. Notify provider. If medical needed, pend for 10 days. Once final decision is reached, 3 days to notify provider. 30 days if treatment already rendered.	If C86 motion, Right Fax to MCO; enter V3 note. Investigate request; issue due process letter; staff with MCO, file review/IME as needed; issue BWC Order within 28 days; email MCO with final BWC/IC decision after all appeals exhausted.	N/A	Conduct hearing for any appeals to BWC Order.
Retro C-9 Date of Service falls between the A/I LPDOS and the A/I LPDOS + 13 months or there is no A/I LPDOS in V3.	Process in normal manner; do not refer for claim reactivation review. MCO may need to ask BWC for manual reactivation.	No review or order is issued. May need to manually activate claim for MCO.	N/A	N/A
Retro C-9 Date of Service is more than 24 months of the A/I LPDOS.	If a valid request, refer to BWC for Claim Reactivation Review.	Process in accordance with the policy –investigate, issue due process, staff, file review/IME as needed & issue decision within 28 days.	N/A	Conduct hearing for any appeals to BWC Order.
Durable Medical Equipment or Prosthetic	Process specific DMEs & all prosthetics as normal, email BWC to manually activate claim if approved **or** if the request is for DME/Prosthetic and treatment refer to BWC for review.	Manually activate claim if approved by the MCO. No review or order needed **or** process in accordance with the policy –investigate, issue due process, staff, file review/IME as needed, & issue decision within 28 days.	N/A	Conduct hearing for any appeals to BWC Order.
Medical Bill Payment	Pay bill if DOS prior to inactive date. Request manual activation of claim from BWC if claim needs it prior to making payment.	Manually activate claim if requested by the MCO.	N/A	Conduct hearing for any appeals to BWC Order.
Pharmacy Services	N/A	Process in accordance with the policy –investigate, issue due process, staff, file review/IME as needed, & issue decision within 28 days.	Submit bill to PBM. If allowed, payment for prescription will be sent to the pharmacy, & the pharmacy should reimburse the IW.	Conduct hearing for any appeals to BWC Order.
Vocational Rehabilitation	If valid request, MCO request Claim Reactivation review. MCO will work with BWC (CSS & DMC) to issue decision.	Process in accordance with the policy –investigate, issue due process, staff with DMC and MCO as appropriate and & issue decision within 28 days.	N/A	Conduct hearing for any appeals to BWC Order.

E. INDEPENDENT MEDICAL EXAMINATION (IME)

An *Independent Medical Examination (IME)* is an objective medical evaluation conducted by an independent, qualified medical specialist. With the implementation of HPP, an IME may be provided by the MCO or BWC, depending upon the circumstances of the claim.

During a medical examination requested by BWC or the MCO, the injured worker may have a relative or significant other present if so desired. If the injured worker is unable to communicate due to deafness or a foreign language barrier, an interpreter may be present (see Interpreter Services in Chapter 3). Injured workers' representatives, employers' representatives and MCOs' representatives may not be present during independent medical examinations. Electronic recording equipment, audio or visual is not permitted in the examination room or of the examination.

1. MCOs Conducting IMEs

Per Rule 4123-6-04.3(F), an MCO may schedule an IME of the injured worker on BWC's behalf to assist in the alternative dispute resolution (ADR) process. See Chapter 5 of the MCO Policy Reference Guide for more information on MCO Scheduled/BWC Reimbursed ADR IMEs.

2. CCT Responsibilities

The CCT will continue to be responsible for scheduling IMEs to address:

- Statutory requirements (90 Day, 200 Week, Permanent Partial Disability C-92, Occupational Disease).
- Requests for claim allowances and loss of use awards.
- Requests to reactivate a claim.
- Exams requested to support BWC's dispute resolution process.
- The CCT must select a physician of the same or similar provider specialty from the BWC established Disability Evaluator Panel. This panel is comprised of qualified medical specialists who have met credentialing requirements for the performance of IMEs and signed a written agreement with BWC.

3. IMEs Required by Statute

a. 90 Day Examinations (Statewide Disability Evaluation System/SDES)

R.C. 4123.53(B) requires that an injured worker be examined after receiving 90 days of consecutive temporary total disability compensation. This evaluation determines the injured worker's:

- Continued entitlement to temporary total disability compensation benefits;
- Rehabilitation potential;
- Appropriateness of care.

A 90 examination can be waived upon written agreement of the employer or if a statement is obtained from the POR that indicates that the injured worker has reached MMI.

b. 200 Week Examinations

R.C. 4123.56 requires that an injured worker be examined after receiving 200 weeks of temporary total compensation to determine extent of disability or continued entitlement to temporary total disability compensation benefits.

c. Occupational Disease Allowance Examinations

R.C. 4123.68 requires that an injured worker be examined prior to determining a claim allowance for the following occupational diseases:

- Berylliosis;
- Silicosis;
- Asbestosis;
- Coal miner's pneumoconiosis;
- Cardiovascular or pulmonary disease (firefighters or police officers);
- Any other occupational disease of the respiratory tract resulting from injurious exposure to dust.

d. Permanent Partial Impairment (C-92) Examinations

R.C. 4123.57 requires an examination once an injured worker has filed for a permanent partial disability award to determine percentage of permanent impairment in accordance with the 5th edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*. BWC is responsible for C-92 examinations for injured workers of both state-fund and self-insuring employers.

Examinations not required by statute, but requested as deemed necessary by the CCT, include those for:

- Initial and subsequent claim allowances, such as recognition of psychological conditions;
- Loss of use awards and those requested to support BWC's dispute resolution process.

Physicians and medical professionals in BWC's statewide Disability Evaluators Panel perform examinations (and medical file reviews). The panel is comprised of more than 800 qualified medical specialists who meet BWC's requirements for performing examinations. Emphasis is placed on the credentials and qualifications of physicians performing examinations and on the quality of examination reports.

For additional information on the Disability Evaluators Panel, contact BWC's DEP Coordinator at (614) 752-8664.

4. Disability Management Independent Medical Evaluation (DM IME)

BWC's goal for claims management is to facilitate the earliest possible safe return to work and to ensure appropriate and timely medical treatment. To reach this goal, BWC schedules Disability Management Independent Medical Exams (DM IME) to evaluate the treatment and extent of disability early in life of the claim.

a. Reviewing Claims for a DM IME

BWC schedules DM IMEs for injured workers who have received temporary total (TT) compensation, when there has been a total of 45, 90, 135, or 180 accumulated days of disability. After 180 days of disability, the injured worker is scheduled for an IME as the need is identified based on activity in the claim.

The CCT sets a 601 diary in the claim for the review date, based on the chart below, in all claims where TT is being paid. The review is to be completed and the exam scheduled as close to the IME target date as possible.

Days to Review/Schedule for IME	**IME Target Date**
30 Days	45 Days
75 Days	*90 Days
120 Days	135 Days
165 Days	180 Days
*Statutorily required for TT claims unless waived by Employer of Record.	

Prior to scheduling an exam, the CCT reviews the claim to determine if the claim meets any of the exception criteria that would exclude the injured worker from the exam process. The following exceptions **exclude** a claim from being scheduled for a DM IME:

- Claims where the exam would be scheduled by the out-of-state exam vendor;
- Statutory occupational disease and catastrophic claims; or
- Evidence is on file indicating a confirmed RTW.

The following exception conditions in a claim result in **delaying** the claim from being scheduled for a DM IME:

- The claim is not in an allowed status;
- The claim or requested conditions are being appealed;
- Additional allowances are pending;
- A C-9 is found in the medical records requesting approval of surgery not yet performed. If the injured worker refuses to have the approved surgery the exception no longer applies;
- Evidence is on file indicating a planned return to work within the next 14 calendar days or the injured worker is released to work with restrictions; or
- The injured worker has been approved for or is enrolled in a BWC approved rehabilitation program.

In these claims, the CCT sets a diary for a follow-up review after the 30 day review date. Claims are reviewed every 14 days, or at the appropriate timeframe, to determine if the claim continues to be an exception or if the injured worker should be scheduled for an exam. Follow-up reviews continue until an exam is scheduled or there is a confirmed RTW in the claim.

BWC utilizes Ohio-specific outcome measures to determine expected lengths of disability for select surgical procedures and certain conditions. Surgeries are identified on

the Expected Duration of Disability Due to Surgery chart; conditions are outlined in the Expected Duration of Disability for Select Allowed Conditions chart. IMEs may be postponed until the expected length of disability has elapsed. IMEs may also be postponed if there is evidence in the claim of a subsequent surgical procedure or if there is a significant complication requiring treatment and delaying resolution. Claims falling into these criteria should be staffed (formally or informally) by the CCT including the MCO case manager prior to scheduling the IME or delaying the IME for a medical reason.

When the follow-up review is completed and the claim meets the exception criteria, a V3 Note is entered documenting why the DM IME was delayed and the diary target date is extended to the next appropriate review date.

b. Physician selection

Physician selection in the IME process is critical for obtaining appropriate exam results that can be used to facilitate appropriate future medical care for the injured worker and a safe early return to work. The CCT formally or informally staffs with the team's Medical Service Specialist (MSS) to determine the type of physician to be used for the exam.

Consideration is given to the following when selecting an appropriate physician to conduct a DM IME:

- Ideal physicians include a specialist for a given body part such as orthopedics or physical medicine and rehabilitation for spinal conditions. (Particularly at 90 days and beyond.)
- Physicians providing treatment to injured workers in the region covered by the Customer Service Office should be given preference.
- If a physician is at or approaching the cap for the Customer Service Office, please notify the BWC Medical Director for possible waiver to allow this type of evaluation.
- If no physician is available locally or it is not possible to schedule a timely exam, it may be necessary to require the injured worker to travel to a metropolitan area.

c. Physician Reimbursement

Physicians are reimbursed for the independent medical exam and the report using DEP "W" Code W1170.

If the injured worker fails to show for the evaluation and the evaluation was not canceled at least two business days prior to the date of the evaluation, the physician faxes the questionnaire with the appropriate box checked to BWC. The physician then may submit a bill for the administrative memo using code W1171.

Addendum requests follow established BWC procedures and reimbursement based on the issues requiring the addendum.

d. Standard questions for the DM IME

The type and consistency of the questions asked of the independent medical examiner are critical in achieving consistent maximum results across the state. These standard

questions, which can also be accessed in DOGS, are included in the V3 Notice to the Examining Physician Correspondence.

1) Based on your review of the medical records and information you obtained from your evaluation of the injured worker, is the current treatment necessary and appropriate for the allowed condition(s) in the claim according to nationally accepted treatment guidelines? Please explain the rationale for your opinion as it specifically applies to this Injured Worker.

2) Based on your review of the medical records and information you obtained from your evaluation of the injured worker, are there additional diagnostic or treatment services consistent with Official Disability Guidelines that should be considered that would be reasonably expected to improve the treatment outcomes of the allowed condition(s) in this claim? If so, what are the diagnostic or treatment services that should be considered and what may be the expected outcome in most cases if they were provided? Please provide rationale such as treatment guidelines, position papers, or standards of medical care to support your opinion.

3) Based on your review of the medical records and information you obtained from your evaluation of the injured worker, what activity (including work) restrictions/limitations appear to be appropriate based on the current status of the allowed conditions in the claim. (Do not focus on the type of work performed by the individual but rather on their activity capacity, restrictions, or limitations.) Please complete the DEP Physician's Report of Work Ability (C143) .
4) In your medical opinion, has the injured worker reached maximum medical improvement (MMI)? MMI means the condition has stabilized and no fundamental, functional or physiological change can be expected in the condition despite continued medical treatment and/or rehabilitation. Please explain the rationale for your opinion.

   Add this question to all 90-day exam letters to the DEP: If the injured worker has not reached MMI, when should a re-examination be considered?

5) If the injured worker has not reached MMI, is vocational rehabilitation appropriate from a medical perspective? Please specify services recommended. (Note: An injured worker may be eligible for vocational rehabilitation services when the allowed injury or illness in the claim creates a significant impediment to returning to employment or maintaining employment and has job restrictions as a result of the allowed conditions in the claim or sustained a catastrophic injury claim and a vocational goal can be established.)

Except in cases where the DM IME coincides with the 90 day exam, the DM IME is tracked **as an extent of disability exam** in exam scheduling. This exam allows the CCT to document an MMI outcome if the examining physician opines regarding MMI.

e. DM IME and 90 day exams

In claims in which 90 consecutive days of TT compensation have been paid, the statutorily required IME must be done unless a waiver is received from the employer.

The 90 day exam must be done even if the claim meets the exception criteria for the DM IME. **These exams are tracked as 90 day exams in exam scheduling.**

If the DM IME that is to be scheduled at 45 days is delayed and the claim is close to the 90 day statutorily required exam, the CCT contacts the employer and explains that BWC would like to schedule an IME that will occur close to but before the 90 day exam and request an waiver for the 90 day exam. If the employer refuses to waive the 90 day exam, the IME will not be scheduled until the 90 day exam can be done.

f. IME Results

The success of the DM IME hinges on the CCT's ability to effectively collaborate with the MCO Case Manager, employer, and, potentially, the treating physician regarding the DEP's conclusions and recommendations in a timely manner.

Within 3 business days of receipt of the report:

- The CCT shares each report received with the Provider of Record and MCO by faxing it from V3 imaging or informing the assigned MCO case manager by e-mail that the report is available in imaging.
- Quality assurance reviews are completed and medical issues found in the report are acted upon.
- The MCO Case Manager evaluates the report and contacts the POR as necessary regarding the DEP's conclusions and recommendations for treatment requested in questions 1 and 2. This information should be available to facilitate appropriate medical care in an expedited manner or to assist the MCO in authorization and/or denial of medical services.
- The MCO contacts the employer and injured worker, if appropriate, regarding the DEP's conclusions on restrictions and work ability requested in question 3 to facilitate early RTW via transitional work or modified/light duty.
    - If the employer is able to accommodate the work ability, the MCO shall facilitate return to work with the POR. It is not necessary to contact the injured worker if the employer is unable or unwilling to accommodate the work ability. Staff the claim to determine if an EM Referral is appropriate or alternative work is available.
- The CCT initiates appropriate administrative actions regarding the DEP's opinion on the issue of Maximum Medical Improvement (MMI) requested in question 4. If MMI is found by the DEP examining physician:
    - For injured workers receiving Temporary Total compensation, the CCT contacts the POR to determine his/her opinion regarding MMI. If a response is not received within five business days, the CCT refers the issue to the Industrial Commission (IC).
    - The CCT and/or MCO Case Manager make appropriate referral for vocational rehabilitation services if the DEP's conclusions from Question 5 support these services.

F. OCCUPATIONAL DISEASE (OD) CLAIMS

R.C. 4123.68 provides a list of diseases that are always identified as occupational diseases. These diseases are contracted through an industrial process, described in the schedule of diseases. These diseases may be caused by exposure to:

- dust, gases or fumes;
- chemicals and toxic substances;
- extreme changes of temperatures, noises or pressure;
- physical vibrations, constant pressure and use, physical movement in constant repetition;
- radioactive rays;
- infections and organisms;
- radiation.

1. Distinguishing Between an Injury and an Occupational Disease

An OD generally results from repeated work-related exposure; the exposure has a harmful effect on the employee. There is a causal relationship between the exposure and the harmful effect that is confirmed by a medical diagnosis. Conditions of employment create a greater hazard to the worker than to other workers in general. The MCO must consider the mechanism of or process causing the disease, the type of employment and any other pertinent information.

2. Time Limits for Filing an OD Claim (R.C. 4123.85)

a. Filing of OD Claim

Claims for an OD or a death resulting from an OD, must be filed within:

- Two years after the disability due to when the disease began; or
- Such longer period as does not exceed six months after a diagnosis as an OD is made by a licensed physician.
- Within 2 years after death occurs

For example: The injured worker may be experiencing a disability but the disease is not diagnosed as work-related until more than two (2) years after the disability began. Once the disease causing the disability is diagnosed as causally-related to the injured worker's occupation, then the injured worker has six (6) months to file an OD claim after the date of diagnosis as an OD.

b. R.C. 4123.28

R.C. 4123.28 extends the statute of limitations by one (1) day for every day the employer fails to report a lost-time injury or OD or death up to an additional two (2) years.

3. Payment of Medical Bills Prior to Date of Disease.

Medical bills incurred for diagnostic exams and/or treatment in OD claims can be paid for services provided for a period up to two years prior to the date of disability. Payment for services exceeding the two year period may be approved based on a formal order by the Industrial Commission.

The MCO must use override EOB 783 to submit bills for reimbursement in these cases. Services must be related to the allowed condition(s) or pass the three-part test as mandated by the Miller court case.

G. DEATH CLAIMS

Death claims are defined as claims in which a work-related injury or an occupational disease contracted by an employee causes his/her death. Death must be physical in nature (brain death excluded) and may occur instantly or may occur subsequent to the initial injury or illness. Eligible dependents may apply for death benefits as outlined in R.C. 4123.59. Death claims must be filed within two years of the date of death. Death claims are Lost Time claims and should never be filed as medical only claims. The MCO shall not submit a claim as an accident or occupational disease claim where the claim should have been submitted as a death claim because the injured worker is deceased as a result of the industrial accident or injury for which the claim is being filed. If the injured worker has died as a result of something other than the industrial accident or injury for which the claim is being filed the MCO must submit the Date of Death on the initial 148. The MO/LT indicator is submitted in the "Coverage Code" field. The values of Accident, Death, or Occupational Disease are submitted in "Type of Accident" field. If the death is a result of the industrial accident, the claim should be sent in with a coverage code of LT, accident type of Death, and the Date of Death field populated. If the death is not a result of the industrial accident, the claim should be sent in with a coverage code of MO or LT (depending on the number of days missed), accident type of Accident or OD (not Death), and the Date of Death field populated. Refer to the Information Systems Documentation for further information on filing death claims.

H. FORCED SEXUAL CONDUCT

Effective 8/25/2006, pursuant to Senate Bill 7, a compensable injury includes a psychiatric condition sustained by the employee where the psychiatric condition has arisen from sexual conduct in which the individual was forced by threat of physical harm to engage or participate.

This provision of the law (R.C. 4123.01(C)(1)) opened the door for the allowance of emotional or stress claims absent a physical injury. Under current Ohio workers' compensation law, this is the **only** situation that permits an individual to have a claim allowed for a psychiatric condition with no physical injury.

1. Initial Allowance

When BWC receives an initial application requesting allowance of a psychiatric condition only as a result of forced sexual conduct, the investigation and other succeeding processes should be treated the same as any other claim requesting a psych condition as an initial allowance. The only difference is that most other claims will request allowance of a physical injury as well as the psychiatric condition.

2. Gathering and Evaluating Evidence

According to Joint Resolution R03-1-01, all motions or applications filed on or after March 1, 2003 requesting the allowance of a psychiatric condition shall be accompanied by supporting evidence consisting of a medical report by a licensed psychiatric specialist,

a clinical psychologist, a licensed professional clinical counselor, or a licensed independent social worker.

BWC does not require an Independent Medical Examination (IME) for all claims alleging a psychiatric condition as a result of forced sexual conduct; however, an IME or file review may be appropriate to develop evidence to support our decision. When an IME has been completed, it will be necessary for BWC to review and evaluate the psychiatric report.

An Injured Worker Affidavit (Declaration Statement) is **not** required for this type of claim. The Affidavit is mandatory for those claims where an IW is requesting an **additional** allowance of a psychiatric condition.

When a claim is filed requesting allowance of a psychiatric condition only as a result of forced sexual conduct, it may be necessary to discuss the claim with a BWC Attorney during a team staffing and prior to allowance; however, staffing with an attorney is not a requirement.

3. Issuing the Decision

Once BWC's investigation is complete and the Customer Care Team (CCT) has made a decision regarding claim allowance, a BWC Order will be issued and held for a 14-day appeal period unless waivers have been received by the appropriate parties. If BWC's order is appealed to the Industrial Commission (IC), compensation and medical benefits may be payable according to R.C. 4123.511(H) and (I). BWC will notify the MCO of the final decision after all appeal periods have expired.

The Customer Care Team (CCT) should e-mail the "ICD-9 Modification Req" e-mail box to add the psychiatric condition to the claim when it is the only claim allowance.

4. Paying Compensation

When considering payment of compensation, it is important to remember that psychiatric service providers have the same requirements by law and BWC rules and guidelines as physical medicine providers.

Licensed Medical Doctors (M.D.s) and Doctors of Osteopathic Medicine (D.O.s) are licensed to treat psychiatric/psychological conditions. Licensed Independent Social Workers (LISW) and Licensed Professional Clinical Counselors (LPCC) do not have to work under the supervision of a psychiatrist or psychologist. They may work independently to request treatment and provide medical/psych services to injured workers, but they cannot sign any form used for compensation (C-84, Medco 14). They are not permitted to be a Physician of Record (POR) and deal with issues of compensation.

5. Subsequent Request

Psychiatric conditions resulting from forced sexual conduct may be allowed in a claim as a subsequent request and compensation may be payable as a result of the additional claim allowance.

I. SUBSTANTIAL AGGRAVATION OF A PRE-EXISTING CONDITION

1. Introduction

Claims with date of injury on or after 8/25/2006 may be allowed for substantial aggravation of a pre-existing condition.

The substantial aggravation must be documented by objective diagnostic findings, objective clinical findings, or objective test results. Subjective complaints may be evidence of a substantial aggravation, but they are insufficient to support allowance of a substantial aggravation without objective diagnostic findings, objective clinical findings, or objective test results.

Once the condition has returned to a level that would have existed without the injury, no compensation or benefits are payable for the pre-existing condition. Therefore, a claim will always be *allowed* for substantial aggravation of a pre-existing condition once it has become a claim allowance; however, compensation and benefits may not be payable when the condition returns to a level that would have existed without the injury.

2. Guidelines and Considerations for Claim Allowance

To determine if substantial aggravation of a pre-existing condition should be considered as a claim allowance, review the medical documentation submitted to support the allowance. A condition should not be considered for allowance as a substantial aggravation simply because the injured worker (IW) had been previously treated for that condition.

When considering a condition for allowance (initial or subsequent) of substantial aggravation, the Claims Service Specialist (CSS) will verify that the condition pre-existed the injury. Examples include degenerative arthritis or other degenerative diseases, diabetes, or other chronic conditions that are not directly related to the injury itself, but are substantially aggravated by the injury. There should be an incident described that caused a specific injury (lumbrosacral sprain, for example) and then the pre-existing condition that has been substantially aggravated by the injury (degenerative arthritis, for example).

It is not necessary for the word "substantial" to be included in a request for allowance of a substantially aggravated pre-existing condition. For claims with a date of injury on or after 8/25/06, any request for an aggravation of a pre-existing condition is to be investigated and determined under the guidelines for substantial aggravation. For claims with a date of injury prior to 8/25/06, aggravation of a pre-existing condition may still be considered for allowance, but the request will not be subject to the guidelines for substantial aggravation.

The fact that a previous claim exists/existed for the same or similar condition is **not** enough information to consider a condition for substantial aggravation. Sprains/strains should not be considered for allowance of a substantially aggravated pre-existing condition simply because the injured worker has or had a previous claim allowed for the same or similar condition. However, a sprain/strain may be allowed

in a new claim if there is evidence of a specific incident that supports a new injury. Substantial aggravation of a pre-existing sprain/strain must be considered for allowance if it is specifically requested on a motion or other written request.

Example 1: The injured worker (IW) has a previously allowed claim for ankle sprain. The condition resolved and the IW returned to work. Now, a new claim has been filed with a new accident description and a diagnosis of ankle sprain. This claim would not be considered for allowance of substantial aggravation of pre-existing ankle sprain because the condition cannot be supported by objective medical evidence that meets the evidentiary requirements of the law. However, the claim may be considered for allowance of ankle sprain.

Example 2: The IW has a previously allowed claim for lumbar sprain. The IW continued to seek treatment for the condition and now has a new accident with a requested diagnosis of lumbar sprain. This claim would not be considered for allowance of substantial aggravation of pre-existing lumbar sprain because no definitive objective findings or objective diagnostic tests will support allowance of the condition. However, the claim may be considered for allowance of lumbar sprain, or the Customer Care Team (CCT) may discover that benefits for the new accident should be attributed to the previously-allowed claim.

Example 3: The IW has contracted dermatitis as the result of exposure to chemicals, but the condition is not work-related. At the workplace, the IW is exposed to chemicals and develops dermatitis. This claim may be allowed for substantial aggravation of pre-existing dermatitis if the dermatitis is a chronic condition for which the IW is currently receiving ongoing treatment and a specific incident occurs that substantially aggravates the pre-existing dermatitis. Dermatitis can also be an acute condition related to a particular incident that is treated and resolved and it may not be considered pre-existing. If there is evidence the previous dermatitis had resolved and there is a new specific incident with evidence supporting the new injury, dermatitis may be allowed in the new claim.

A psychological condition may be allowed for substantial aggravation if the alleged condition is supported by sufficient objective medical evidence and proof of a causal relationship. An exam will be required to determine if the condition was truly aggravated and any disputes may be resolved at the Industrial Commission (IC).

3. Gathering Evidence

When a request to allow a claim for substantial aggravation of a pre-existing condition is filed, the Claims Service Specialist/Medical Claims Specialist must staff the claim with a Medical Service Specialist (MSS) to determine if an independent medical exam (IME) or a physician file review is appropriate. The Injury Management Supervisor/Medical Claims Specialist Supervisor and other available resources should be included in staffing as needed. When the request for allowance is supported by the evidence mandated by law and a causal relationship statement, neither an IME nor a physician file review is necessary. Exam

and file review questions for claims with a date of injury on or after 8/25/06 may be found on BWC's Claims Online Resources (COR). A review by the MSS may determine that sufficient evidence has been submitted and the Claims Service Specialist (CSS) may issue a BWC Order to allow the condition based upon the MSS's evaluation of the claim.

Consider the following factors when deciding between an exam and a physician file review:

- Complexity of the claim: Complex claims may benefit from an exam, but a physician file review may be sufficient for minor injuries.
- Presence of Co-morbidities or Pre-existing Conditions: An exam is recommended when medical evidence submitted reveals other conditions which may be impacting the injured worker's current complaints.
- Age of Injured Worker: The age of the injured worker (IW) may impact the severity of the injury and determine if an exam or physician file review is necessary.
- Presence of Supporting Medical Evidence: A physician file review may be sufficient if supporting medical documentation and diagnostic tests are on file.

An exam may be appropriate in the following situations:

- A new claim is filed requesting allowance of substantial aggravation of a pre-existing condition.
- The IW has other claims allowed (settled or unsettled) for the substantially aggravated pre-existing condition being requested.
- The IW has reached maximum medical improvement for conditions allowed in the claim and a substantial aggravation of a pre-existing condition has been requested.

Following the nurse's review of the evidence on file, he/she will enter a Version 3 (V3) note to document and provide justification for scheduling an exam, requesting a physician file review, or recommending allowance of the condition without an exam or review. The V3 note will also list the supporting objective medical evidence on file and the presence or absence of a causal relationship statement.

Prior to an IME, the Customer Care Team (CCT) should be encouraging the IW to submit any and all medical evidence that will support allowance of the condition. The CCT may also contact the managed care organization (MCO) to request medical evidence.

Following receipt of the IME findings, BWC will address the requested condition via referral to the Industrial Commission (IC) or BWC Order.

If BWC's IME report states that the IW did not submit sufficient objective

medical evidence, an initial allowance should be denied and a subsequent allowance should be referred to the IC with a recommendation for denial as the objective diagnostic findings, objective test results, or objective clinical findings do not support allowance of the condition. The IW did not meet the burden of proof.

If some evidence is submitted, but it appears to be insufficient, an exam or physician file review is appropriate to determine allowance of the condition.

If the CCT cannot obtain *any* evidence prior to the exam, an initial request should be denied and a subsequent request should be dismissed.

If objective medical evidence is submitted that indicates an aggravation of a pre-existing condition has occurred, but no causal relationship statement is present, the CCT should attempt to obtain a causal relationship statement.

The following types of medical evidence/documentation may be submitted and/or gathered for decisions involving a substantially aggravated pre-existing condition(s):

- Lab reports, X-rays, MRI, CT reports or any other diagnostic tests that may document the current status of the substantially aggravated pre-existing condition;
- Lab reports, X-rays, MRI, CT reports or other diagnostic tests pertaining to the condition prior to the injury;
- Documentation of current medication including dosage and frequency for substantially aggravated pre-existing condition (i.e. insulin or pain medication);
- Documentation of medication including dosage and frequency for substantially aggravated pre-existing condition that IW was receiving prior to the date of injury;
- Any objective physician examination findings of substantially aggravated pre-existing condition prior to injury and subsequent to injury;
- PT, OT records prior to and subsequent to injury;
- Emergency Room reports;
- Accident reports;
- Operative reports.

Evidence of the status of the injured worker's pre-existing condition prior to the incident that caused the substantial aggravation may be found in objective evidence submitted by the injured worker during initial allowance of the condition; however, such evidence is not required for allowance of substantial aggravation of a pre-existing condition.

4. Evaluating the Evidence

If an injured worker (IW) does not request substantial aggravation of a pre-existing condition on his/her initial application, BWC will not pursue allowing the condition until the IW submits a request to allow the condition in the claim.

Example:

- A new claim is filed and the alleged conditions are injuries directly caused by the incident (lumbar and thoracic sprain/strain).
- A review of the medical evidence on file indicates that a pre-existing condition may have been substantially aggravated, also.
- Because the initial application does not indicate a request for allowance of the condition that was aggravated, BWC will not pursue allowance of that condition.

If an IW files an initial request for allowance of substantial aggravation of a pre-existing condition and other conditions, but there is no evidence on file to support allowance of the substantially aggravated pre-existing condition, objective medical evidence to support allowance must be requested. If no evidence or insufficient evidence is received, the CCT may address the other conditions and state that the substantially aggravated pre-existing condition will be considered upon submission of supporting medical documentation.

Example:

- An initial request is filed asking for allowance of substantial aggravation of pre-existing arthritis of the knee, knee sprain/strain, and contusion of the knee.
- Evidence on file supports allowance of the knee sprain/strain and contusion, but there is no evidence on file to support allowance of substantial aggravation of pre-existing arthritis of the knee.
- Objective medical evidence is requested, but none is received.
- A BWC Order may be issued to allow the knee sprain/strain and contusion and also state that substantial aggravation of pre-existing arthritis of the knee will be considered upon submission of supporting medical documentation.

If an IW files a request for allowance (initial or subsequent) and the alleged conditions include a condition that may be considered for substantial aggravation (degenerative disc disease), BWC will obtain a medical opinion asking if the condition was directly caused or substantially aggravated by the injury.

If the medical opinion states that the condition was substantially aggravated by the incident, BWC will allow the claim for substantial aggravation of the pre-existing condition. The condition will be allowed by direct causation if it is supported by the medical opinion.

Example:

- Initial or subsequent request is filed asking for allowance of lumbar and thoracic sprain/strain, as well as degenerative disc disease (DDD).
- BWC obtains a medical opinion to determine if DDD was directly caused

by the injury or substantially aggravated by the injury.

- The claim will be allowed for *substantial aggravation of pre-existing* DDD if the medical opinion supports such a finding.
- The claim will be allowed for DDD if the condition is supported by the medical opinion.

When this type of request is submitted as a subsequent request and it is determined that the condition was substantially aggravated by the injury, the CCT should contact the requesting party to clarify that they agree to move forward and consider allowance of the requested condition as a substantial aggravation of a pre-existing condition.

5. Issuing the Decision

Once BWC's investigation is complete, the decision will be communicated to all parties of the claim.

For initial or subsequent decisions in which a condition directly caused by the injury is requested along with a substantially aggravated pre-existing condition, BWC will address the requested conditions on the same order to avoid confusion among parties to the claim and the Industrial Commission (IC).

The MCO will be notified of the final decision by BWC.

a. Initial Decision

BWC will issue an Initial Allowance or Initial Denial Order to notify all parties in the claim of the decision.

The BWC Order will be held for a 14-day appeal period unless the appeal period is waived by the parties in the claim. Payment of compensation will not be held if the employer has certified the claim. If BWC's order is appealed, the claim will be decided by the Industrial Commission at a hearing and compensation and benefits are not payable at this time.

If the appeal period expires and no appeal is filed; the decision is final and compensation and benefits may be payable for the substantially aggravated pre-existing condition.

V3 will be updated accordingly based upon the final BWC/IC decision. BWC will notify the MCO of the final BWC/IC decision by e-mail after all appeal periods have expired.

b. Subsequent Decision

When a substantially aggravated pre-existing condition is being added to a claim as a subsequent allowance, BWC will issue an Additional Allowance/Wages/Compensation Order to notify all parties in the claim of the allowance decision.

However, the issue will be referred to the Industrial Commission when a conflict in evidence exists and BWC is not allowing the condition.

The BWC Order will be held for a 14-day appeal period unless the appeal period is waived by the parties in the claim. If the order is appealed, the issue will be decided by the IC at a hearing and compensation and benefits for the substantially aggravated pre-existing condition are not payable at this time.

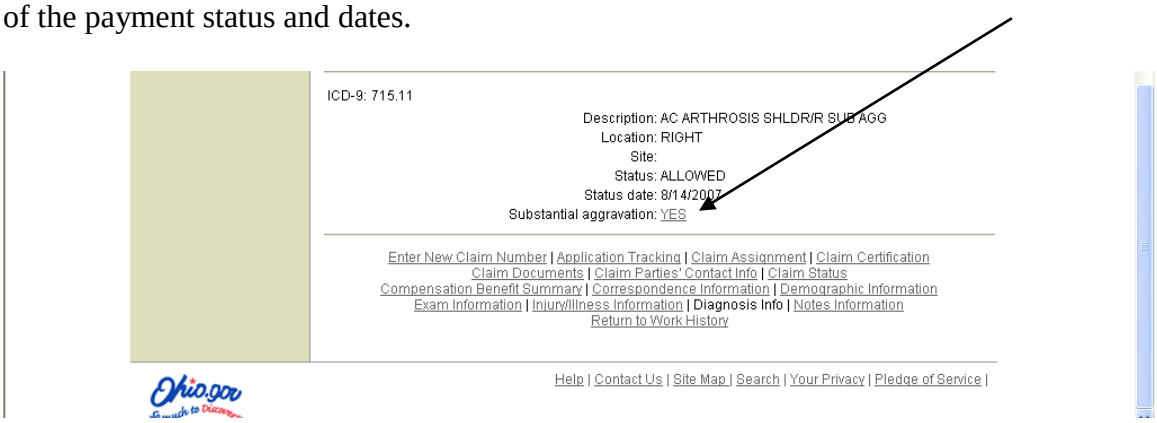
If the appeal period expires and no appeal is filed; the decision will be final and compensation and benefits will be payable for the condition.

V3 will be updated accordingly based upon the final BWC/IC decision. BWC will notify the MCO of the final BWC/IC decision by e-mail after all appeal periods have expired.

C.) Substantial aggravation claims - detail of payable/non-payable statuses.

To locate the substantial aggravation information on www.ohiobwc.com, go to Injured Workers, Diagnosis information.

If the Substantial Aggravation flag is YES for an ICD, you can click on the flag to get the detail of the payment status and dates.



Once you click on the Yes flag, it takes you to the screen which contains the status history with the effective dates.

6. Condition Returned to a Level That Would Have Existed without the Injury

According to R.C. 4123.54(G), no compensation or benefits are payable for a substantially aggravated pre-existing condition once that condition has returned to a level that would have existed without the injury. When this occurs, BWC will complete an investigation and issue a decision when no conflict exists or refer the issue to the Industrial Commission when a conflict does exist.

a. Motion or other written request filed

When the CCT receives a motion or other written request asking for termination of compensation and medical benefits because the pre-existing condition has returned to a level that would have existed without the injury, due process will be provided.

Depending upon the evidence submitted, BWC may schedule an IME to determine the status of the injured worker's condition.

BWC will contact the MCO to request assistance in gathering appropriate medical evidence and to provide notice to them that the condition may have returned to a level that would have existed without the injury.

b. Condition Has Returned to a Level That Would Have Existed without the Injury

When BWC's investigation reveals that the condition has returned to a level that would have existed without the injury, the injured worker's physician of record (POR) should be contacted by letter. BWC will ask the physician of record if he/she agrees or disagrees with the findings and to provide a response to BWC in writing within seven calendar days.

If an exam has been completed in the course of the investigation, a copy of the exam should be attached to the letter sent to the POR. The supporting evidence filed with the motion or other written request should also be sent to the POR.

If the POR agrees that the injured worker's substantially aggravated pre-existing condition has returned to a level that would have existed without the injury, BWC

will issue a Miscellaneous Order to all parties as notification that compensation and benefits are no longer payable for that condition.

The BWC Order will be held for a 14-day appeal period unless the appeal period is waived by the parties in the claim. If BWC's order is appealed, the issue will be decided by the IC at a hearing, and compensation and benefits for the substantially aggravated pre-existing condition will remain payable pending a final decision by the IC.

If the appeal period expires and no appeal is filed, the decision will be final and compensation and benefits will no longer be payable for the substantially aggravated pre-existing condition only.

V3 will be updated accordingly based upon the final BWC/IC decision. BWC will notify the MCO of the final BWC/IC decision by e-mail after all appeal periods have expired.

If the POR disagrees with BWC's findings or sends no response within seven calendar days, the issue will be referred to the IC. Compensation and benefits for the substantially aggravated pre-existing condition will remain payable pending a final decision by the IC.

c. Condition Not Returned to a Level That Would Have Existed without the Injury

When BWC's investigation of the motion/request reveals that the condition has not returned to a level that would have existed without the injury, the issue will be referred to the Industrial Commission (IC) for hearing.

Compensation and benefits for the substantially aggravated pre-existing condition will remain payable pending a final decision by the IC.

V3 will be updated accordingly based upon the IC's decision. BWC will notify the MCO of the final IC decision by e-mail after all appeal periods have expired.

8. Evidence on File

When evidence on file indicates that the substantially aggravated pre-existing condition *may* have returned to a level that would have existed without the injury, BWC should contact the MCO to request any additional medical evidence they may have to assist BWC with making a decision. BWC will not schedule an exam or request a file review to develop the evidence.

a. Evidence Indicates Condition Has Returned to a Level That Would Have Existed without the Injury

If all evidence clearly reveals that the condition has returned to a level that would have existed without the injury, due process will be provided to determine if all parties agree with BWC's decision.

The injured worker's physician of record (POR) should be contacted by letter to verify if he/she agrees or disagrees with our findings and to provide a response to BWC in writing within seven calendar days.

If the evidence used to support BWC's decision to pursue termination of compensation and medical benefits has been submitted by the POR, it is not necessary to send the letter to the POR.

If the POR agrees that the injured worker's substantially aggravated pre-existing condition has returned to a level that would have existed without the injury, BWC will issue a Miscellaneous Order to all parties as notification that compensation and benefits are no longer payable for that condition.

The BWC Order will be held for a 14-day appeal period unless the appeal period is waived by the parties in the claim. If BWC's order is appealed, the issue will be decided by the Industrial Commission (IC) at a hearing, and compensation and benefits for the substantially aggravated pre-existing condition will remain payable pending a final decision by the IC.

If the appeal period expires and no appeal is filed; the decision will be final and compensation and benefits will no longer be payable for the substantially aggravated pre-existing condition only.

V3 will be updated accordingly based upon the final BWC/IC decision. BWC will notify the MCO of the final BWC/IC decision by e-mail after all appeal periods have expired.

If the POR disagrees with BWC's findings or sends no response within seven calendar days, the issue will be referred to the IC.

Compensation and benefits for the substantially aggravated pre-existing condition will remain payable pending a final decision by the IC.

V3 will be updated accordingly based upon the IC's final decision. BWC will notify the MCO of the final IC decision by e-mail after all appeal periods have expired.

b. Evidence Does Not Indicate Condition Has Returned to a Level That Would Have Existed without the Injury

If all evidence on file does **not** clearly indicate that the condition has returned to a level that would have existed without the injury, BWC will not pursue an exam or file review at this time.

An exam or file review should never be requested or scheduled to develop further medical evidence. The results of the exam or file review may create a conflict in evidence and BWC has no jurisdiction to issue a decision when a conflict in evidence exists.

9. Treatment Requests Received When Condition Resolved

The MCO must consider requests for medical treatment when a final BWC/IC decision has determined that the substantially aggravated pre-existing condition has returned to a level that would have existed without the injury and other conditions are allowed in the claim. If the request is denied and an appeal is filed, the issue will go through the Alternative Dispute Resolution (ADR) process.

If the substantially aggravated pre-existing condition is the only condition allowed in the claim, treatment requests will be dismissed without prejudice once a final BWC/IC decision has determined that the condition has returned to a level that would have existed without the injury.

10. Compensation Requests Received When Condition Resolved

Once a final decision is rendered and it has been determined that the injured worker's substantially aggravated pre-existing condition has returned to a level that would have existed without the injury, compensation requests for the condition will be referred to the IC.

If a C-84 is filed listing a substantially aggravated pre-existing condition(s) along with other allowed conditions, the Claims Service Specialist (CSS) should contact the physician of record (POR) to verify which condition(s) in the claim is/are preventing the injured worker from returning to work. The CSS should also inform the POR that the substantially aggravated pre-existing condition(s) is/are no longer payable.

If the injured worker's POR states that the injured worker is temporarily and totally disabled due to the other allowed condition(s), the injured worker is eligible for Temporary Total Compensation (TT). The CSS should not deny TT because the substantially aggravated pre-existing condition(s) is/are listed on the form.

11. Request to "re-open" a substantially aggravated pre-existing condition

A motion or other written request to "re-open" a period of substantial aggravation should be reviewed and investigated much like an initial allowance request. The burden of proof to support the request with objective evidence and a statement demonstrating causal relationship falls upon the party filing the request.

a. Gathering and Evaluating Evidence

When a motion or other written request is received asking BWC to "reopen" a period of substantial aggravation for a pre-existing condition, due process will be provided.

BWC will contact the MCO to request assistance in gathering appropriate medical evidence and to provide notice to them that compensation and benefits for the substantially aggravated pre-existing condition may be requested.

BWC may schedule an IME to determine the status of the IW's condition.

b. Issuing the Decision

If BWC's investigation reveals that the motion or written request should be approved because the condition is no longer at a level that would have existed without the injury, BWC will issue a Miscellaneous Order to all parties as notification that compensation and benefits are payable for that condition only.

If the Industrial Commission (IC) issued a previous decision stating that the condition has returned to a level that would have existed without the injury, the issue will be referred to the IC.

The BWC Order will be held for a 14-day appeal period unless the appeal period is waived by the parties in the claim. If BWC's order is appealed, the issue will be decided by the IC at a hearing and compensation and benefits for the substantially aggravated pre-existing condition will not be payable pending a final decision by the IC.

If the appeal period expires and no appeal is filed; the decision will be final and compensation and benefits will be payable for the substantially aggravated pre-existing condition only.

V3 will be updated accordingly based upon the final BWC/IC decision. BWC will notify the managed care organization (MCO) of the final BWC/IC decision by e-mail after all appeal periods have expired.

If BWC's investigation reveals that the motion or written request should not be approved or the IC issued a previous decision stating that the condition has resolved, the issue will be referred to the IC. Compensation and benefits for the substantially aggravated pre-existing condition will not be payable pending a final decision by the IC.

V3 will be updated accordingly based upon the IC's decision. BWC will notify the MCO of the final IC decision by e-mail after all appeal periods have expired

J. BANKRUPT SI CLAIMS

The BWC SI Bankrupt team in the Central Office handles bankrupt self-insuring employer claims. Every SI employer must pay an assessment to the self-insuring employer's guarantee (surety) fund for the first 3 years of SI. Should a SI employer default on payments of compensation or benefits to the employees of the employer, the payments are made by BWC and recovered from the guarantee (surety) fund, based on the date of the claim.

Upon receipt of the bankrupt employer's claims, the SI Bankrupt team ultimately functions as the "employer/administrator". The SI Bankrupt team retains the same responsibilities as any employer would with regards to administration of their claims. This may include

appealing medical and treatment decisions. Therefore, the SI Bankrupt team works closely with the MCO. The SI bankrupt team has the employer's files and most of the time the information in the files is not reflected in V3 until the employer's file is audited. Because of these unusual circumstances, the team encourages the MCO to phone or e-mail them when handling their claims. The MCO will receive a list of the team members, phone numbers, claim number assignment and e-mail addresses.

When a Self-Insuring employer defaults many things have to take place in a very short time. Depending on the size of the employer and the number of claims the initial process will vary. The following is a hierarchy of this process:

- The MCO is selected within 24 hours of the notification of default
- The defaulting employer's files are received within 3-14 days depending on their size and location
- First focus is to ensure the injured worker continues to timely receive compensation without a break in benefits:
    - Active claims and those in which medical issues have not been addressed are attended to
    - Coordination with the MCO to provide the medical necessary for working with providers
    - V3 system is updated to allow prescriptions to be paid through PBM, the pharmacy benefits manager
    - Identification of medical only claims that have issues to be addressed or claim numbers assigned

SI employers are not required by law to file medical only claims with the BWC. The team assigns claim numbers to the medical only claims allowed by the former SI employer. The claims may range from a few days to several years old when the number is assigned. Contact the assigned Claim Service Specialist (CSS) if there are concerns with the age of a claim. Upon input, the claims status will be "new claim" and within 24 hours the status will be changed to "allow" and the conditions allowed by the employer will be identified.

The MCO is encouraged to consult with the BWC CSS on the SI team prior to paying bills on a SI Bankrupt inactive claim in order to consider the lag time in treatment (i.e. an intervening event which caused the injured worker to seek treatment). An opportunity to investigate relatedness and causality may be lost if the bills are automatically paid upon receipt.

1. **Claims Management**
    - **a.** Once the Self-Insured (SI) employer defaults the selected MCO will be notified by the Self-Insured Team's supervisor with a phone call to ensure the selected MCO wishes to accept the employer's files. This is followed up with a letter and e-mail.

    - **b.** Claims are assigned by the last 2 digits of a BWC claim number excluding the suffix -22.

c. The Self-Insured team is the MCOs primary point of contact for all claim issues. Together the MCO and the customer care team can discuss issues in the claim and bring those issues to a successful resolution. The customer care team is also the MCO resource regarding BWC's claims law and policy.

d. Self-Insured Bankruptcy claims are primarily lost time claims. Many times the ICD-9 codes allowed may need to be re-evaluated to reflect the more specific condition. Contact the assigned claims service specialist to discuss.

e. Notification and reporting of "new" claims or "new claim allowances" will be performed by the Self-Insured Bankruptcy team. The team will notify the specific MCO directly.

f. Initial decision

- SI Bankruptcy claim decisions in most cases have been determined by the former SI employer

g. Legal and medical issues regarding additional allowances

- The physician of Record (POR) may request additional conditions on a C-9 form or other medical document
- After review of medical evidence the Customer care team (CCT) may allow the additional condition/s by BWC order
- If evidence does not support requested allowance the CCT will notify the MCO and injured worker that a C-86 motion is required for further consideration of the issue. The MCO will then deny the C-9 and request a C-86 motion from the injured worker to be submitted to the CCT
- C-86 motions for reactivation of a claim should be forwarded to the CCT for resolution
- C-86 motions requesting treatment that are not dependent upon BWC determination or an allowance issue will be forwarded to the MCO. i.e. Motion requesting allowance of herniated disc and surgery would not be provided to the MCO until BWC determines the allowance.

h. Claim Re-Activation

- When a claim is inactive, request for re-activation will be submitted to the Customer care team. A request to "activate" a claim absent a request for some additional action, such as, allowance of additional condition, compensation payments, or treatment, is not a valid request. BWC will not consider activating a claim unless there is a request for additional allowance, compensation payment or treatment.
- Bills that have not been paid due to the default of the Self-Insured employer do not require "re-activation" of the claim.
- Bills should be reviewed by the CCT to determine bill payment. If it is determined the bill should be paid, the CCT will temporarily activate the claim only for the purpose of reimbursement. Once the bill has been paid, the claim will be returned to an inactive status.

NOTE: refer to "Active In-active Work Flow" page 2-55

i. Electronic Data Interface (EDI) 148

- The MCO will notify the CCT if a 148 is not received. The CCT will refresh the system to facilitate claims data visualization.

k. MCO's case management and coordination with BWC:

- Regardless of the MCO's criteria, the MCO shall have a case management plan that meets the requirements of the version of the URAC Case Management Standards under which the MCO is accredited for all lost time cases where the injured worker has not returned to work. MCO's are required to fax this plan and any addendums/revisions to SI Bankrupt team imaging fax number within 2 business days of completion of the plan or revision.

  NOTE: The V3 system is not accurate until the CCT audits the SI employer's files and updates the system.

l. ICD-9-CM:

- The SI Bankrupt Team will identify the primary ICD-9 codes and note in V3.
- V3 ICD-9 codes may conflict with the treating ICD-9 codes submitted on C-9 forms. In this case, contact the CCT for clarification and possible update of the V3 system.

m. Catastrophic claims:

- In cases of SI Bankrupt claims, the BWC SI Bankrupt team will act as "employer/administrator" and the MCO that is assigned the SI Bankrupt claim will provide medical case-management.

n. Records Management:

- Upon the SI Bankrupt team's review of the employer's files to determine the need for appropriate allowances and review and payment of ongoing compensation, the MCO will then receive the updated BWC claim files.
- Rule 4123-3-23 allows providers to file fee bills within one year from the date the services were rendered or within one year from the date the services became payable under R.C. 4123.511(I), whichever is later.

  - Because of the SI Employer's previous financial situation, many bills may have gone unpaid. In addition, because of the transition of bankruptcy, bills may be sent to an already defaulted SI Employer or their former Third Party Administrator. This may result in old bills and duplicates being filed.
  - It is an acceptable practice to return bills to the provider within the first 30 days of the transition. A letter should be sent to the provider along with the bill instructing the provider to re-bill if the employer's last check did

not cover the invoice in question. You may contact the BWC SI Bankrupt team for a copy of this letter.

.i.e. Miller: IW had original injury resulting in arthritis of the knee. This condition required IW to have total knee replacement. Within two years of surgical procedure, total knee prosthesis fractured resulting in one time complication and surgical repair of total knee appliance. This complication meets all three *Miller* criteria as reasonably related, reasonably necessary and cost of services are medically reasonable. A formal allowance is not required in these cases.

i.e. Flow Through: IW had surgery to inguinal hernia. As a result the repair the bowel was perforated. IW subsequently developed sepsis. In this case although not a "generalized condition" both these ailments will affect the IW's entire body. Treatment should be reimbursed utilizing BWC's "flow through" policy. Formal allowance is not required in this case.

2. Standard Prior Authorization:

- Presumptive approval
  The MCO is discouraged in using "Disclaimer" language for treatment requested which is not in an allowed status. (SI Bankrupt team has 28 days to make a determination regarding additional conditions)
- Standard Prior Authorization:
  Prior authorization is required after the first 60 days following an injury for physical medicine services, including chiropractic/osteopathic manipulative treatment and acupuncture.

Note: Greater than 90% of all bankrupt claims are past the 60 day timeframe.

- Disclaimers

  For additional conditions requested on a C-9, the MCO will deny the treatment request and forward the request to SI Bankrupt team for review.

BWC Diagnosis Determination Guidelines – Quick Reference

BWC relies on Managed Care Organizations to gather pertinent medical documentation from all treating providers to support the allowance determination. To perform this function efficiently, BWC, MCOs and providers need to know the guidelines and criteria for diagnosis determination essential to substantiate diagnoses in claims. The medical documentation contained in the claim file is critical as evidence for the claims determination especially when this evidence is presented for a hearing.

The primary objective of the Diagnosis Determination Guidelines is implementation of consistent criteria for diagnosis determination/coding decisions between BWC and the MCOs. These documents are to be utilized as reference tools. The document "BWC Diagnosis Determination Guidelines" is the detailed expanded version to be utilized as a reference manual if a guideline is unclear in the abbreviated document. The document "BWC Diagnosis Determination – Quick Reference" is the abbreviated version of the first document "BWC Diagnosis Determination Guidelines". This lists the ICD code with the diagnosis narrative description, subjective and objective exam findings, diagnostic tests and findings for diagnosis substantiation. The medical reports, documentation and diagnostic tests are submitted to the customer care team to assist in the claim determination. The Diagnosis Determination Guidelines are located in Shared Documents, MCO Update Page Documents folder on the MCO portal.

These documents are not intended to direct medical care or to be utilized in authorization of medical treatment. In determination of allowed diagnoses in a claim it is appropriate to perform diagnostic studies to determine or rule out those conditions which have specific diagnostic requirements**.**